MANAGED CARE ENTERPRISE LIABILITY: TOWARD A NEW PARADIGM OF MEDICAL MALPRACTICE

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ABSTRACT

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Willis Chou

This thesis examines the law of medical malpractice in light of managed care, and argues that the traditional physician-centered model of malpractice liability is incompatible with the cost reforms of managed care. Managed care organizations employ a host of strategies to reduce or contain medical costs, many of which invariably have clinical consequences. Physicians are no longer autonomous with respect to medical decision making, yet they remain the primary targets in malpractice litigation. A potentially superior alternative to the current tort system is managed care enterprise liability, where the risk of malpractice would be borne exclusively by the integrated health care enterprise.

After tracing the origins of enterprise liability from products liability law, this thesis argues for its applicability in the health care context. First, theories of managed care liability are examined in order to establish a legal basis for enterprise liability. Next, enterprise liability is supported from a public policy perspective, because it best reconciles the normative goals of a liability system (compensation of victims, prevention of injuries, promotion of quality care, and reduction of administrative expenses) with cost reform.

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I. INTRODUCTION

President Clinton's controversial Health Security Act of 1993 (the "Clinton Plan")[1] underscored the growing concern for comprehensive health care reform in the United States.[2] This concern has largely arisen from a perceived two-part "crisis" in health care. The first is a crisis of spiraling medical costs,[3] coupled with a lack of adequate insurance coverage for many. These two events are causally related. Rising health care costs have imposed an increasing burden on employers and governments,[4] which have

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[1] Health Security Act, H.R. 3600, S. 1757, 103d Cong., 1st Sess. (1993). The Act was the product of nine months of research and drafting by the Health Care Task Force headed by Hillary R. Clinton, and featured the concept of "managed competition" to provide cost-effective medical care.

[2] For an excellent discussion of the policy issues that need to be addressed by health care reform, see James F. Blumstein, *Health Care Reform: The Policy Context*, 29 Wake Forest L. Rev. 15 (1994); Robert J. Blendon et al., *Making the Critical Choices*, 267 JAMA 2509 (1992).

[3] In 1993, Americans spent roughly $3900 per person on health care, for a total of $942.5 billion. International Trade Admin., U.S. Dep't of Commerce, U.S. Industrial Outlook 1994, at 42-2 (1994). Over the past forty years, spending for health care has grown 3% per annum faster than expenditures for all other goods and services. It now accounts for approximately 14% of the GNP. If the current rate of growth continues, health care spending would represent almost one-third of the GNP by the year 2030. *See* Victor R. Fuchs, *No Pain, No Gain: Perspectives on Cost Containment*, 269 JAMA 631 (1993); Henry J. Aaron, Serious and Unstable Condition: Financing America's Health Care (1991).

[4] Corporate employers complain that rising health care costs place them at a competitive disadvantage in the international marketplace. *See* Kenneth R. Wing, *American Health Policy in the 1980's*, 36 Case W. Res. L. Rev. 608, 672-75 (1986). Meanwhile, the health care entitlement programs of Medicare and Medicaid continue to consume an ever-greater

been the traditional sources of health care insurance.[5] As employers have dropped or limited insurance to reduce their costs, an ever-growing number of Americans have become uninsured.[6]

The second crisis concerns the state of medical malpractice. Malpractice insurance premiums skyrocketed from $60 million in 1960 to more than $7 billion by 1990,[7] prompting unprecedented physician walkouts and an uproar for state tort law reform.[8] A great deal of dissatisfaction has been voiced by all the relevant parties - physicians,

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portion of the federal budget. *See* Board of Trustees Report, *A Proposal for Financing Health Care of the Elderly*, 256 JAMA 3379 (1986).

[5] Because the United States has never adopted a national health insurance program, a dual system of public and private third-party insurance gradually developed to help patients cover the costs of illness. *See* Paul Starr, The Social Transformation of American Medicine 235-334 (1982).

[6] Approximately 85% of the population is currently covered by some sort of health insurance plan, usually employer or government provided. Yet an estimated thirty-five to forty million Americans lack insurance coverage at any one time. *See* Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 JAMA 2491 (1991).

[7] Paul C. Weiler, Medical Malpractice on Trial 2 (1991).

[8] In 1975, doctors throughout much of California staged a month-long protest strike against rising insurance rates. *See* Henry Weinstein, N.Y. Times, May 29, 1975, at 1, col. 4. Waves of legislative activity addressing tort and insurance reform took place in 1975-76 and again in 1985-86. *See generally* Randall R. Bovbjerg, *Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card*, 22 U.C. Davis L. Rev. 499 (1989); Glen O. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, 49 Law & Contemp. Probs. 5 (Spring 1986). *See also infra* notes 131-143 and accompanying text.

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employers

patients, insurers and attorneys - with respect to the overall process by which the legal system assigns liability, as well as compensates the victims of injuries.

Physicians experience enormous economic and emotional costs, and feel the need to practice medicine defensively.[9] Injured patients complain that the current tort system is an unfair and unpredictable lottery that can take years to achieve resolution. Insurance companies note that increased loss ratios and restrictive state regulation have made insurance underwriting burdensome and unprofitable. In the face of such difficult and expensive litigation, malpractice attorneys hesitate to accept any but the most attractive cases.[10]

The Clinton Plan attempted to address both the cost and malpractice crises. To control medical costs and provide greater health care access, the Clinton Plan proposed a three-tier hierarchy of organizations to regulate and

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[9] The total costs of medical professional liability were estimated to be $12-13 billion in 1984. These costs include liability insurance premiums and the indirect costs of defensive medicine (tests and procedures done to minimize the threat of litigation). Roger A. Reynolds et al., *The Cost of Medical Professional Liability*, 257 JAMA 2776 (1987).

[10] *See* Larry M. Pollack, *Medical Maloccurrence Insurance (MMI): A First-Party, No-Fault Insurance Proposal for Resolving the Medical Malpractice Controversy*, 23 Tort & Ins. L.J. 552, 552 (1988).

provide health care services. This hierarchy combined sweeping government regulation with private market initiatives. The first two tiers contemplated governmental control in the forms of a National Health Board and Health Insurance Purchasing Cooperatives ("HIPCs").[11] The third tier was to be represented by Managed Care Organizations ("MCOs") - integrated health plans consisting of physicians, hospitals, and insurance companies.[12]

While a bold approach was taken toward the cost crisis, the Clinton Plan addressed the malpractice crisis in a more understated manner. Early reports suggested that the Clinton Plan would embrace the innovative theory of "enterprise liability."[13] Under enterprise liability, the

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[11] The National Health Board would have overseen the entire system, setting broad guidelines and determining a global budget. HIPCs, or "health alliances", would have functioned as quasi-governmental organizations created by the states to oversee the process by which private health plans offer medical coverage. By pooling large numbers of subscribers, HIPCs would have obtained greater bargaining power. For a complete description of the organizations proposed under the Clinton Plan, see the text of the Health Security Act, *supra* note 1.

[12] The strategy of managed competition was at the heart of the Clinton Plan, which also included cost-sharing requirements (deductibles, coinsurance and copayments) and caps on premium increases. *See* Walter A. Zelman, *The Rationale Behind the Clinton Health Care Reform Plan*, Health Affairs, Spring 1994, at 9.

[13] In June 1993, Task Force member Robert Berenson, M.D., publicly discussed the enterprise liability theory with respect to the Clinton Plan. *Currents*, Hosp. & Health Networks, Aug. 5, 1993, at 23. *See also* Mark Crane, *The Malpractice Reform Idea that Won't Go Away*, Med. Econ., July 26, 1993, at 27; Robert Pear, *Changing Health Care: Clinton Advisers Outline Big Shift for Malpractice*, N.Y. Times, May 21, 1993, at

locus of liability for medical malpractice would shift from the individual physician to the provider organization.[14] Instead of readily endorsing enterprise liability, many physicians sharply criticized its inclusion in the Clinton Plan.[15] Enterprise liability was objected to on the grounds that it would cause MCOs to demand greater control over medical decision making, further reducing physician autonomy.[16] In response to this unexpected opposition, the final version of the Clinton Plan did not mandate enterprise

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A1; Sara Fritz & David Savage, *Health Reform Plan May Exempt Doctors from Suits*, L.A. Times, May 5, 1993, at A1.

[14] These organizations might include hospitals and hospital alliance systems, as well as forms of MCOs responsible for financing and providing care to a defined patient population. *See* William M. Sage et al., *Enterprise Liability for Medical Malpractice and Health Care Quality Improvement*, 20 Am. J.L. & Med. 1 (1994) (comprehensively discussing enterprise liability and its potential effect on the quality of health care).

[15] The American Medical Association and Physician Insurer Association of America (PIAA) flexed their collective lobbying might to discourage the adoption of enterprise liability. *See, e.g.*, Brian McCormick, *Enterprise Liability Out*, Am. Med. News, June 28, 1993, at 1; David Rogers, *Initial Clinton Medical Malpractice Reform Plan Pulled After Resistance by Entrenched Interests*, Wall St. J., June 15, 1993, at A20.

[16] There were other objections as well. The PIAA, a trade association of physician-owned insurance companies, saw enterprise liability as a threat to its relevance. The AMA objected because it favored alternative state tort reforms, such as caps on jury awards and mandatory arbitration. Enterprise liability was seen as simply a second-best option.

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liability, but instead merely offered federal funds to states wishing to establish "demonstration projects."[17]

Despite ultimately failing in Congress, the Clinton Plan's central theme - the widespread adoption of integrated health plans - has been usurped by the private marketplace.[18] Startling changes in the health care market have occurred in the past decade: a series of mergers and acquisitions in the hospital and pharmaceutical industries; an increased presence of for-profit corporations in the hospital sector; a greater willingness of employers and other large purchasers to negotiate directly with providers and insurers to control health costs; and, most importantly, the growth of managed care.[19]

The term "managed care" is not monolithic; rather, it encompasses a continuum of possible organizational structures. In this paper, MCO is intended as an umbrella

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[17] *See* Health Security Act, *supra* note 1, at§ 5311. The demonstration projects would have served as experiments to determine whether enterprise liability could improve quality, reduce defensive medicine, and allow for better risk management.

[18] *See* Erik Eckholm, *While Congress Remains Silent, Health Care Transforms Itself*, N.Y. Times, Dec. 18, 1994,§ 1, at 1. For a criticism of health care being increasingly subject to the ethics of the marketplace, see Jerome P. Kassirer, *Managed Care and the Morality of the Marketplace*, 333 New Eng. J. Med. 50 (1995).

[19] *See generally* Keith M. Korenchuk, Transforming the Delivery of Health Care: The Integration Process (1994).

term referring to the range of these entities. An MCO is perhaps best conceptualized as a union, in varying degrees, of the financing (or payor) function with that of the delivery (or provider) function. MCOs negotiate with both providers (physicians and hospitals) and subscribers (groups of patients) to deliver health care for a fixed amount of payment on a per-capita basis. This consolidated approach stands in contrast to traditional "fee-for-service" medicine.[20]

Although MCOs can assume a variety of forms, they share certain general characteristics. Common to all forms is an attempt to control costs by modifying the manner in which health care resources are utilized. MCOs employ a host of strategies to provide cost-effective care, including capitation, utilization review, practice guidelines, financial incentive systems, and the use of gatekeepers.[21] These methods of cost control have altered the physician-patient relationship in two critical ways.

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[20] Under fee-for-service, physicians and hospitals are paid a separate amount for each service rendered. This is the financial arrangement seen in traditional indemnity and service-benefit plans. *See* Starr, *supra* note 5, at 63, 291-92.

[21] *See infra* notes 56-65 and accompanying text for a more complete discussion of these cost-containment strategies.

First, through utilization review, practice guidelines and the use of gatekeepers, the MCO achieves the ability to direct the means and methods of providing health care services. Second, the MCO induces compliance with cost containment by means of capitation and financial incentives; stated otherwise, the MCO transfers the financial risk of health insurance from itself to its affiliated physicians. These changes create the possibility that patients may be injured in new ways,[22] and have important implications for medical malpractice.

Historically, malpractice liability has been narrowly applied to the direct provider of health care - the physician. Since the beginning of this century, physicians have exercised virtually complete authority over the standard and delivery of care.[23] In this cultural and

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[22] For example, patients may be denied certain diagnostic procedures and treatments, and their physicians may be prohibited from freely discussing alternative options. At some point, there is an unavoidable conflict between the need to control costs, and the ability to maintain the quality of care delivered. This "dark side" of managed care is discussed at length in Symposium, *The Dark Side of Health Care Containment: Emerging Legal Issues in Managed Care*, 14 Seton Hall Legis. J. 1 (1990). *See also* Arnold S. Relman, *The New Medical-Industrial Complex*, 303 New Eng. J. Med. 963 (1980) (discussing dangers created by the emergence of for-profit health care).

[23] Even though physician fees account for 15-20% of health care costs, physicians control 70-90% of total health care expenditures. The physician's authority to determine whether and where to hospitalize patients provided great leverage over hospitals. Likewise, the ability to prescribe particular drugs and supplies gave physicians similar influence over pharmaceutical companies and medical suppliers. *See*

professional context, where physicians were sovereign with respect to care, it was appropriate that they bore sole liability for negligent actions.

The twin crises of cost and malpractice have recently invited much debate over controlling medical costs, as well as reforming liability law. Unfortunately, these debates have taken place simultaneously but in relative isolation from one another. Very little attention has been given to evaluating both problems as part of a coherent strategy. This is a serious shortcoming, for it is impossible to grasp the full dimensions of the crises without seeing that they are inextricably connected.

The law of malpractice did not arise from a vacuum; rather, it has been rooted in the economic, cultural, and ethical reality of medical practice over the past century.[24]

Starr, *supra* note 5, at 26-27; Arnold S. Relman, *The Allocation of Medical Resources by Physicians*, 55 J. Med. Educ. 99, 99 (1980) (arguing that, because physicians effectively control the vast majority of health resources, only by modifying physician behavior can medical costs be restrained).

[24] The system of cross-subsidization and third-party insurance reimbursement effectively shielded both providers and patients from cost concerns. Patients had little incentive to refrain from seeking care because a third party was paying (a problem of moral hazard), and providers had the incentive to provide all care that could be of any benefit. This economic scenario contributed to the ethical norm that viewed the physician as a fiduciary expected to deploy scarce health resources for the benefit of the individual patient without regard to broader societal concerns. *See* E. Haavi Morreim, *Redefining Quality by Reassigning Responsibility*, 20 Am. J.L. & Med. 79 (1994).

For much of this erstwhile period, physicians could determine care independent of cost. Indeed, malpractice law forbade physicians from altering the standard of care based on their patient's financial status.[25] The rapid expansion of managed care has fundamentally changed this dynamic.

Cost decisions that invariably have clinical consequences are now made by corporate managers, yet liability continues to be based on an outdated view of medical practice.[26] Physicians have already lost their monopoly on medical control,[27] and it is time for them to lose their monopoly on liability as well. This thesis argues that the traditional physician-centered model of malpractice should be replaced by managed care enterprise

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[25] As one court explained, "whether the patient be a pauper or a millionaire, whether he be treated gratuitously or for reward, the physician owes him precisely the same measure of duty, and the same degree of skill and care." John A. Siliciano, *Wealth, Equity, and the Unitary Medical Malpractice Standard*, 77 Va. L. Rev. 439, 441-42 (1991) (quoting Becker v. Janinski, 15 N.Y.S. 675, 677 (C.P. N.Y. City & County 1891)). This legal requirement does not, however, preclude disparities in care based upon ability to pay, even though it is so intended.

[26] As one physician commented, "We have moved from a world where the payor calls the doctor to one where the payor calls the tune." Duffy & Slayman, *Managed Care and Managed Competition*, *in* Driving Down Health Care Costs: Strategies & Solutions, 1990, at 203 (1989).

[27] Physicians have managed to achieve a state-sanctioned monopoly over the medical profession through licensing and educational requirements. In addition, the medical profession preserved its authority and autonomy through the legal doctrine prohibiting the "corporate practice of medicine." *See* Starr, *supra* note 5, at 204-20.

liability. Although enterprise liability disappeared from the public forefront with the defeat of the Clinton Plan, the concept has a rich legal history and finds considerable intellectual support.[28]

Part II of this thesis begins by tracing the growth of managed care, and examining some of its more common organizational forms. Part III describes the traditional law of medical malpractice, and the current state of malpractice reform. Part IV outlines the legal bases for managed care liability, and shows how the courts have bypassed executive and legislative inaction to take the lead in establishing various theories of liability against MCOs. Part V explains why enterprise liability would probably better accomplish the normative goals of the liability system than alternative proposals, and Part VI addresses some of the threshold issues involved in testing the comparative advantages of enterprise liability.

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[28] Academic support for medical enterprise liability has existed for a number of years. *See generally* Barry R. Furrow, *Symposium: Enterprise Liability and Health Care Reform: Managing Care and Managing Risk*, 39 St. Louis L.J. 77 (1994); Weiler, Medical Malpractice on Trial, *supra* note 7, at 122-32; 2 American Law Inst., Reporters' Study: Enterprise Responsibility for Personal Injury 113-19 (1991).

II. CHARACTERISTICS OF MANAGED CARE

A. THE GROWTH OF MANAGED CARE

MCOs have grown in both number and significance in recent years.[29] Today, 57% of the entire U.S. population is enrolled in managed care.[30] Of the 160 million people with employer-sponsored health insurance, an estimated 65% are under some form of MCO; by contrast, only 5-10% were enrolled in such plans in 1980.[31] Approximately 83% of physicians are under contract with at least one MCO.[32] One recent analysis predicts that by the year 2000, up to 65% of all Americans will receive their health care through integrated managed care plans.[33]

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[29] This transition has been especially painful for elite academic centers, which have struggled to maintain their research and teaching roles in the face of cost containment. *See* Elisabeth Rosenthal, *Elite Hospitals of New York City in Financial Bind*, N.Y. Times, February 13, 1995, at A1, B4; Milt Freudenheim, *Hospitals' New Creed: Less is Best*, N.Y. Times, Nov. 29, 1994, at D1.

[30] Geri Aston, *HHS: Managed Care Applied Brakes to '95 Health Spending*, Am. Med. News, Feb. 17, 1997, at 5.

[31] Jon Gabel et al., *The Changing World of Group Health Insurance*, Health Affairs, Summer 1988, at 48.

[32] Aston, *supra* note 30, at 5; Physicians participating in any form of MCO derive, on average, 35% of their revenues from managed care sources. Solo practitioners have substantially lower rates of participation (39%) than physicians in large group practices (78%). John K. Iglehart, *Health Policy Report: Physicians and the Growth of Managed Care*, 331 New Eng. J. Med. 1167 (1994).

[33] *Id.* at 1167. Even traditional indemnity insurance is now usually provided as managed fee-for-service coverage, because physicians services are subject to external utilization review. *Id.*

The origins of managed care can be traced back to the late 1920s, where, in 1927, the Community Hospital of Elk City, Oklahoma, established the first medical cooperative. In 1929, the Ross-Loos Medical Group arranged to provide medical care on a prepaid basis to employees of the Los Angeles Water and Power Department.[34] During the mid-1930s, the Kaiser Foundation Health Plans delivered multispecialty prepaid health care to Kaiser employees working on the Grand Coulee Dam in Washington State; from this modest beginning arose Kaiser Permanente, the largest MCO in existence today.[35]

Managed care remained a rather quiescent concept until the 1970s, when sharply rising medical costs prompted private employers to consider alternatives to fee-for-service health care.[36] Prior to the 1970s, the third-party

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[34] *See* Diana J. Bearden & Bryan J. Maedgen, *Emerging Theories of Liability in the Managed Health Care Industry*, 47 Baylor L. Rev. 285, 291 (1995).

[35] Jack K. Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 Am J.L. & Med. 7, 27 (1996).

[36] *See supra* note 3. Health care spending rose from $12.7 billion in 1950 to $458 billion in 1986. During the same period, the average cost of a hospital stay rose from $127 to $3,527. These rates of increase were four times greater than the rate of inflation over the same period. Health Ins. Ass'n of America, Source Book of Health Insurance Data 17 (1988).

insurance system had generally reimbursed medical care on an open-ended basis, covering all care that was "medically necessary."[37] Under this arrangement, neither patients (whose costs were paid by a third party) nor providers (who were reimbursed more by providing more service) had much incentive to economize; not surprisingly, costs rose.[38]

A further boost to the development of MCOs came from the Nixon Administration, which was seeking to promote forms of preventative care. After President Nixon signed the Health Maintenance Organization Act of 1973,[39] health maintenance organizations ("HMOs")[40] meeting federal standards could demand that large businesses providing

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[37] For a historical account of the third-party insurance system, see R. Fein, Medical Care, Medical Costs (1986).

[38] Certainly other factors have also contributed to the persistent escalation of costs: an aging population, newer and more expensive technologies, overcapacity, administrative inefficiencies, government regulation, economic inflation, and malpractice liability. Nonetheless, most commentators agree that lasting cost containment can only be achieved by some restriction of "marginally beneficial" care. The obvious difficulty lies in defining care that is of marginal benefit. *See* Karen Davis et al., Health Care Cost Containment 11 (1990); William B. Schwartz, *The Inevitable Failure of Current Cost-Containment Strategies: Why They Can Provide Only Temporary Relief*, 257 JAMA 220 (1987).

[39] Pub. L. No. 93-222, 87 Stat. 914 (1973) (codified as amended at 42 U.S.C. §§ 300e et seq. (1996)).

[40] The term "health maintenance organization" was originally coined by Paul Elwood in 1970, to emphasize the preventative nature of this form of pre-paid health care. Kilcullen, *supra* note 35, at 26.

health insurance offer their employees a choice: the HMO must be offered as an alternative to conventional insurance.[41] These HMOs were also eligible to obtain financial assistance through federal grants and loans.[42]

Against this backdrop of rising costs and federal support, the successful proliferation of managed care is related to the overall restructuring of health care that has taken place in the past two decades. As the demand for acute inpatient care has declined, hospitals - once the focal hub of health care delivery - have combined with one another (a form of "horizontal integration")[43] to reduce overcapacity and achieve greater efficiencies.[44] Hospitals

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[41] *Id.* at 26.

[42] A total of $145 million in grants and $219 million in loans were made available to 115 HMOs between 1973 and 1983. *Id.* at 26. HMOs experienced another growth spurt from 1983 to 1988, when HMO coverage was expanded to Medicare and Medicaid eligibles. In addition, almost all states passed enabling statutes to allow HMOs to surmount the barrier presented by the corporate practice of medicine doctrine. Barry R. Furrow et al., Health Law § 8-1, at 309 (1995) (hereinafter Health Law).

[43] Horizontal integration refers to the merger of separate firms, each producing the <u>same</u> good or service, in an attempt to achieve economies of scale and to increase market power. The 1970s and early 1980s were dominated by the horizontal integration of hospitals, both locally as well as national and regional consolidations. Douglas A. Conrad & Stephen M. Shortell, *Integrated Health Systems: Promise and Performance*, 13 Frontiers of Health Services Management 3 (1996).

[44] There were 138 publicly announced hospital mergers and acquisitions in 1995, up from 94 in 1994. Aston, *supra* note 30, at 6.

also restructured themselves by diversifying into those facilities experiencing increased demand: ambulatory, home, rehabilitation, and skilled-nursing care services.[45]

However, the most important kind of restructuring, representing the true essence of managed care, takes the form of "vertical integration." Vertical integration refers to the combination of previously separate firms whose services are inputs to, or outputs from, the production of one another's services.[46] Vertical integration is classically achieved by outright common ownership of the different services; alternatively, as is more commonly the case, the same benefits of ownership can be simulated by an elaborate web of contractual relationships.[47] MCOs "manage care" by vertically integrating the financing and delivery functions.

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[45] Diversification, as opposed to horizontal integration, refers to entering businesses other than the core business. These businesses may or may not be related in some way to the core business. *See* Conrad & Shortell, *supra* note 43.

[46] The economic goals of vertical integration are: (1) to lower transaction costs between separate downstream and upstream processes (e.g., the financing and delivery of care) by substituting within-firm exchanges under a single organization for market transactions between two separate firms, and (2) to achieve economies of scope by sharing common inputs (e.g. physicians and nurses) across related processes. *Id.*

[47] Long-term exclusive contracts, strategic alliances, and carefully constructed interorganizational affiliations all represent means of attaining vertical integration without common ownership. *Id.*

B. COMMON ORGANIZATIONAL FORMS OF MANAGED CARE

Integrated health care systems can be embodied in many different forms,[48] and MCOs can be sponsored by any number of different "players" (e.g., insurance companies, hospitals, employers, unions, community groups, and even physicians have organized to sponsor health plans).[49] The variety of forms and participants reflects the creativity of the legal and business planners. As will be discussed in Part IV of this paper, the particular form of MCO has relevance from a liability standpoint. Two of the more commonly encountered forms of MCOs are described below.

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[48] *See generally* Jonathan P. Weiner & Gregory de Lissovoy, *Razing a Tower of Babel: A Taxonomy for Managed Care and Health Insurance Plans*, 18 J. Health Pol., Pol'y & Law 75 (1993); John K. Iglehart, *The American Health Care System: Managed Care*, 327 New Eng. J. Med. 742 (1992); Robert Shouldice, Introduction to Managed Care: Health Maintenance Organizations, Preferred Provider Organizations, and Competitive Medical Plans (1991).

[49] All types of participants are sponsoring MCOs for various reasons: hospitals to maintain or increase market share; physicians to retain autonomy over clinical practice; insurance companies to increase profits and protect market share; employers to control costs; entrepreneurs of all sorts to profit from a industry experiencing rapid growth. Ironically, the group least actively involved appears to be the one most affected - patients. *See* Vernellia R. Randall, *Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Health Care Cost Containment Injuries*, 17 U. Puget Sound L. Rev. 1, 25 (1993).

1. Health Maintenance Organizations ("HMOs")

An HMO is an entity that provides comprehensive health care to an enrolled membership for a fixed per-capita fee. They represent the most popular form of MCO: over 600 HMOs have a collective enrollment exceeding 56 million Americans.[50] HMOs are typically classified into four sub-categories based on their relationship with providers:[51]

- The staff model HMO directly employs physicians and compensates them as salaried employees. The physicians generally work in facilities owned by the HMO, and receive the benefits of centralized staffing, equipment, and administration.

- The group model HMO contracts with an independent group of physicians (usually an incorporated or partnership multispecialty group practice), rather than employing

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[50] *See* Phil Douglas, *Medicine's Brave New World*, Phys. Practice Dig., Fall 1995, at 12. At the end of 1991, California had the highest HMO penetration, with an enrollment of 41% of the insured population. Massachusetts, Minnesota, and Oregon all had HMO penetration rates in excess of 30%. On the other hand, Arkansas, Idaho, Maine, Montana, North Dakota, South Carolina, South Dakota, and Tennessee all had penetration rates less than 5%. *See* 1 Managed Care Resource Guide 1 (Spring 1994).

[51] *See* Jeannine M. Foran, *Managed Care Systems: Understanding the Phenomenon*, Med. Malpractice L. & Strategy, Apr. 1995, at 1-3.

individual physicians. Care is provided to the HMO's enrollees at the physician group's facilities for a capitated fee.[52]

- The network model HMO contracts with several groups of providers to provide care at a capitated rate. These providers typically also serve patients not belonging to the HMO, such as their separate fee-for-service patients as well as patients enrolled in other MCOs.

- The Individual Practice Association ("IPA") model HMO contracts first with an IPA (usually a corporation or partnership comprised of independent physicians), which in turn contracts with each individual physician. The physicians generally use their own facilities, keep their own records, and maintain private practices outside the HMO. The HMO pays a capitated fee to the IPA, and the IPA then pays each physician on a fee-for-services or other basis.

A recent study of HMOs found that 48% were IPA model, 14% network model, and 38% staff or group-model.[53] As the

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[52] Capitation involves the payment of a lump sum per member as compensation, regardless of the number of services actually provided to each member. Bearden & Maedgen, *supra* note 34, at 293.

[53] Health Law, *supra* note 42, § 8-1, at 309.

industry continues to develop, the lines of distinction among these categories will gradually fade.

2. Preferred Provider Organizations ("PPOs")

The PPO is a more recent innovation whereby organized groups of providers (e.g., hospitals, physicians, lab facilities) contract to offer care at a discounted fee-for-service in exchange for a large volume of subscribers.[54] A PPO more closely resembles traditional insurance in that subscribers are not obligated to use only the preferred providers; however, if a non-preferred provider is chosen, the cost to the subscriber rises.[55]

C. COST-CONTAINMENT STRATEGIES OF MANAGED CARE

Regardless of which form an MCO takes, the ability to control the utilization of resources is key to the cost-containment effort.[56] MCOs use a number of techniques aimed

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[54] Iglehart, *supra* note 32, at 1168.

[55] Patients are strongly encouraged to use the preferred providers through financial incentives such as lower deductibles, higher benefit levels, and reduced or nonexistent coinsurance. *Id.*

[56] For an account of the causes of rising medical costs since 1960, see *supra* note 38 and accompanying text. *See also* Edward B. Hirshfeld, *Commentaries: Should Ethical and Legal Standards for Physicians be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. Pa. L. Rev. 1809, 1819 (1992).

at reducing costs and increasing profits.[57] Some methods stress preventive care, achieve economies of scale, or reduce bureaucratic inefficiencies. Others are far more problematic, directly affecting the physician-patient relationship by striking at the issues of quality and control. These can be broadly classified as either resource restraining or financial risk-shifting strategies.

1. Resource Restraining Strategies

- Utilization Review. Utilization review ("UR") refers to processes used to evaluate the necessity and appropriateness of medical care at various stages in its delivery. UR can occur prospectively, concurrently, or retrospectively, and can be performed by either the MCO or an independent third-party reviewer.[58] Examples of UR

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[57] Profit is a very important consideration for many MCOs, especially those organized as for-profit corporations; many have raised capital from investors by issuing shares in the public equity markets. There has been much criticism that the savings created by MCOs often seem to benefit well-paid corporate managers at the expense of patients. *See* Mike Mitka, *HMO Executives Claim Fat Paychecks*, Am. Med. News, Feb. 5, 1996, at 3 (top managed care salaries ranged from $2.3 million for the CEO of Humana, Inc. to a whopping $14.28 million for the CEO of HealthSource, Inc.).

[58] The effects of prospective or concurrent UR on patient care are potentially much greater than those of retrospective UR. If the physician's proposed clinical plan fails approval, a fundamental conflict arises: the physician will either have to change the treatment plan or provide it anyway with little hope of reimbursement. David D.

include precertification of elective hospitalizations, mandatory second opinions for surgical procedures, and review of hospital lengths of stay and laboratory tests.

- Practice Parameters. Practice parameters are standardized protocols for care based upon empirical evidence. Depending on how much latitude is permitted, they can take the form of guidelines (which are flexible), standards (which are inflexible), or options (which are descriptive protocols but not prescriptive).[59] Practice parameters are also commonly referred to as treatment algorithms, clinical outcomes, or quality-assurance procedures.

- Gatekeepers. Physicians have always served as the de facto gatekeepers to health care.[60] However, as used in the parlance of managed care, "gatekeepers" refer to those primary care physicians who limit specialty care referrals.

Griner, *Paying the Piper: Third-Party Payor Liability for Medical Treatment Decisions*, 25 Ga. L. Rev. 861, 885 (1991).

[59] *See generally* David M. Eddy, *Designing a Practice Policy: Standards, Guidelines and Options*, 263 JAMA 3077 (1990); Lucian L. Leape, *Practice Guidelines and Standards: An Overview*, 16 Quality Rev. Bull. 42 (1990).

[60] *See supra* note 23 (describing how physicians have traditionally controlled the allocation of health care services).

MCOs often require patients to obtain prior gatekeeper approval before access to specialists is permitted.[61]

2. Financial Risk-Shifting Strategies

- Capitation. Capitation *prospectively* reimburses providers a fixed payment per patient, regardless of the amount of services the patient actually requires.[62] If the patient ultimately needs more care than was anticipated, the costs must be absorbed by the provider. This creates a powerful incentive to minimize "unnecessary" care, but may place the physician in conflict with the patient's best interests.[63]

- Financial Incentives. Financial incentive systems tie a provider's compensation to the utilization of medical services, and typically take the form of bonuses and

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[61] Kilcullen, *supra* note 35, at 27.

[62] Hirshfeld, *supra* note 56, at 1827. The concept of capitation is not new. In 1983, Congress adopted the Diagnosis-Related Groups ("DRGs") program for hospitalized Medicare patients. The DRG system created an administrative price system based upon an average cost calculation for a particular diagnosis. Hospitals had a powerful incentive to be "DRG efficient" by keeping real costs lower than DRG reimbursement. *See* Dolenc & Dougherty, *DRGs: The Counterrevolution in Financing Health Care*, 15 Hastings Center Rep. 19 (June 1985).

[63] *See* Boyle, *Should We Learn to Say No*, 252 JAMA 782 (1984) (arguing that physicians should reaffirm their ethical duty to act in the best interests of individual patients, despite increasing cost constraints).

penalties targeted to the amount of resources used over a period of time. Like capitation, they function to influence physician behavior by shifting the risk of health insurance to physicians.[64]

MCOs employ these cost-containment strategies in varying degrees, and no standard pattern exists regarding the possible arrangements for resource control and risk sharing.[65] Several of these strategies seek to reverse the incentives that formerly existed under traditional third-party insurance - under capitation, for instance, the <u>less</u> care that is provided, the more the physician is reimbursed. But how effective are these strategies in actually controlling costs? More importantly, how is the quality of care impacted?

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[64] *Id.*

[65] *See* Marsha R. Gold et al., *A National Survey of the Arrangements Managed-Care Plans Make with Physicians*, 333 New Eng. J. Med. 1678 (1995) (survey of 130 managed care plans found a range of review mechanisms combined with financial incentives to shape physician behavior).

D. IMPACT OF MANAGED CARE ON COST AND QUALITY

Many studies show that managed care has succeeded in reducing health care costs.[66] The Rand Corporation found that HMO enrollees use 40% fewer hospital days and incur 25% fewer expenses than similarly matched patients in fee-for-service plans.[67] Another study by the federal Congressional Budget Office estimated that if all people insured in 1992 had been enrolled in staff- or group-model HMOs, health care costs would have been $78 billion less.[68]

The most recent data reveal that health spending has significantly slowed, growing 5.1% to $937 billion in 1994 and 5.5% to $988.5 billion in 1995 - the lowest rates of growth in three decades. This slowdown was most pronounced in the private sector, where managed care has made the greatest inroads. There, spending increased by just 2.9% in

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[66] *See, e.g.*, Alan L. Hillman et al., *How Do Financial Incentives Affect Physician's Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 New Eng. J. Med. 86 (1989) (finding use of capitation or salaries associated with significantly lower rate of hospital utilization than fee-for-service).

[67] Willard G. Manning et al., *A Controlled Trial of the Effect of a Prepaid Group Practice on the Use of Services*, 310 New Eng. J. Med. 1505 (1984).

[68] Verdon S. Staines, *Potential Impact of Managed Care on National Health Spending*, Health Aff., 1993 Supp., at 248, 253.

1995. According to the Department of Health and Human Services, "This slow growth is linked to the expansion of managed care."[69]

But even if MCOs successfully reduce costs, the quality of care they deliver remains at issue. MCOs are acutely sensitive to criticism that their cost containment might undermine quality. Aware that their economic success depends upon the public's perception of quality, MCOs have tried to control the content of communications through the use of "gag clauses." These restrictive covenants prevent affiliated physicians from freely discussing anything which "could undermine the confidence of enrollees or the public in the <u>quality</u> of coverage" (emphasis added).[70]

Quality is obviously of critical importance, but locating and properly defining quality health care is difficult. A recent study of ambulatory patient responses to different service settings showed a higher degree of

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[69] Aston, *supra* note 30, at 5.

[70] Steffie Woodhander & David U. Himmelstein, *Extreme Risk-The New Corporate Proposition for Physicians*, 333 New Eng. J. Med. 1706, 1706 (1995). Physicians contend that "gag clauses" prevent them from discussing costly treatment options (e.g., bone marrow transplant) or their financial incentives to withhold care. The inclusion of gag clauses in MCO contracts has stirred enormous controversy, prompting many states to enact legislation banning their use. *See* Robert Pear, *Laws Won't Let HMOs Tell Doctors What to Say: 16 States Give Patients Right to be Informed*, N.Y. Times, Sept. 17, 1996, at A12.

satisfaction with solo practitioners than either HMOs or multispecialty groups.[71] Yet, other studies analyzing the utilization of services in treating particular illnesses showed no difference between HMOs and fee-for-service plans. For instance, separate studies comparing HMO and fee-for-service patients with colorectal cancer and rheumatoid arthritis revealed no difference in the care received.[72]

There are two factors that make defining quality difficult. First, there is often a lack of certainty and professional consensus as to appropriate management. For many illnesses, there exists much variation in clinical practice with no apparent differences in outcome (e.g., life expectancy, morbidity, days missed from work).[73] Research examining variations in medical treatment and how patients

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[71] Patient satisfaction, a possible indicator of quality, was measured with respect to a range of issues, including office waits, time spent with providers and availability of appointments. Haya R. Rubin et al., *Patients' Rating of Outpatient Visits in Different Practice Settings*, 270 JAMA 835 (1993).

[72] Reviews of patients with colorectal cancer showed no difference in treatment (surgery, chemotherapy or radiation therapy), length of stay or follow-up visits. Similarly, reviews of patients with rheumatoid arthritis showed no difference in admission rates, length of hospital stay, or rates of surgery. Davis, *supra* note 38, at 213-16.

[73] Different practice styles exist in different regions based on a local concept of good practice. *See The Paradox of Appropriate Care*, 258 JAMA 2568 (1987); David M. Eddy, *Variations in Physician Practice: The Role of Uncertainty*, Health Aff., Summer 1984; John Wennberg & A. Gittlesohn, *Small Area Variations in Health Care Delivery*, 182 Science 1102 (1973).

It is not my intent to judge MCO strategies in a negative light, or to imply that cost containment is not a valid or important societal issue. Rather, the strategies employed by MCOs necessarily implicate malpractice liability because, as the next section explains, current malpractice law demands that physicians adhere to a standard of care without regard to economics.

III. MEDICAL MALPRACTICE LAW

A. BASIC PRINCIPLES OF MALPRACTICE LIABILITY

Traditional medical malpractice is based upon the tort law of negligence.[78] The first medical malpractice case in England, *Stratton v. Cavendish*, was recorded in 1375. In considering the botched hand surgery performed by Dr. Swanlon, the court compared the surgeon's error to that of a smithy: "If a smith undertakes to cure my horse, and the horse is harmed by his negligence or failure to cure in a

[78] Although physicians can be sued under other causes of action (e.g., breach of contract/warranty, infliction of emotional distress, fraud), the tort action of negligence constitutes medical malpractice, and is the major claim by which patients seek redress for injury. *See* Health Law, *supra* note 42,§§ 6-1, 6-4 (discussing other bases of physician liability besides negligence).

reasonable time, it is just that he should be liable" (emphasis added).[79]

To prove a case of medical malpractice, the plaintiff must establish (1) the existence of a physician-patient relationship, (2) the appropriate standard of care, (3) the physician's breach of that standard, and (4) that the physician's breach caused the alleged injury and the damages sustained. In most areas of negligence law,[80] the standard of care is a matter for the jury to determine.[81] However, in medical malpractice cases, the standard of care is based upon custom.[82]

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[79] William Carleton, *Stratton v. Swanlon: The Fourteenth-Century Ancestor of the Law of Malpractice*, The Pharos 20 (Fall 1982). The earliest recorded American case, *Cross v. Guthery*, occurred in 1794 where a husband sued for damages resulting from an unskillful operation on his wife. 1 Am. Dec. 61 (1794). For a historical survey of the development of the American law of malpractice, see Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 Wis. L. Rev. 1193 (1992).

[80] A claim of negligence classically requires that four elements be shown: (1) duty, (2) breach of duty, (3) injury that was proximately caused by breach of duty, and (4) compensable damages. *See* W. Page Keeton et al., Prosser and Keeton on the Law of Torts § 30, at 164-65 (5th ed. 1984).

[81] The jury is typically instructed to evaluate the defendant's conduct under the "reasonable person" standard. *Id.*,§ 32, at 173.

[82] The reasonable person standard presents unique problems in cases of medical malpractice because a lay jury is generally unqualified to judge independently the reasonableness of the physician's conduct. Thus, courts have looked to custom in establishing the required standard of care. *See generally* Patricia M. Danzon, Medical Malpractice: Theory, Evidence, and Public Policy 139-43 (1985) (criticizing the use of custom to define the standard of care); Richard N. Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 Ind. L.J. 528 (1976); Joseph H. King,

The standard of care required is that "which is <u>customary</u> and usual in the profession, ordinarily possessed and employed by members in good standing" (emphasis added).[83] Furthermore, this standard is a unitary one that is applicable regardless of economic resources.[84] Each side attempts to establish the customary standard, and the defendant's compliance or lack thereof, through the testimony of medical experts.[85] Because the law defers this determination to the medical profession,[86] it is incumbent

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Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 Vand. L. Rev. 1213 (1975).

[83] Keeton et al., *supra* note 80,§ 32, at 187, 189. Custom is established in a decentralized, gradual manner by a flow of reports in medical literature, at meetings and in peer discussions. Over a period of time, "hundreds of comments can converge to form a policy, which if widely accepted, will become standard practice." Eddy, *Clinical Policies and the Quality of Clinical Practice*, 307 New Eng. J. Med. 343 (1982).

[84] There are a few exceptions allowing for alternative practice styles (e.g., "two schools of thought", "respectable minority", or "locality rule" doctrines) where these alternatives are each supported by a degree of consensus. Never, however, has the required standard of care been adjusted for economic considerations. *See* Siliciano, *supra* note 25, at 441; E. Haavi Morreim, *Cost Containment and the Standard of Medical Care*, 75 Cal. L. Rev. 1719 (1987).

[85] The ensuing contest has been dubbed as "the battle of the experts." Each expert's testimony can be supported or supplemented by articles in medical journals, research reports, learned treatises, and drug company warnings. *See* Health Law, *supra* note 42,§ 6-2, at 243. The standard of care has evolved under the common law from a locality rule to a national standard for both specialists and generalists. *Id.*,§ 9-2, at 342.

[86] *But see* Helling v. Carey, 519 P.2d 981 (Wash. 1974) (Supreme Court of Washington found negligence even though ophthalmologist acted in full accordance with customary practice (not to routinely screen young

upon the profession itself to formulate clear and consistent guidelines.[87]

The standard of care is a critical concept, because it draws the boundary not only for purposes of medical malpractice, but also between care that is considered "necessary" and "unnecessary." Implicit in the reliance on custom is a supposition that only physicians have the proper authority to define appropriate medical standards of care for society. Likewise, the imposition of a unitary standard makes sense only if physicians are in a position to deliver care without regard to resource constraints.[88] Under managed care, neither of these pretexts continues to exist.

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patients for glaucoma)). Other state courts have declined to independently judge the standard of care.

[87] Whether this is actually accomplished is highly debatable. Many have criticized the battle of experts as a battle of "hired guns", whose contradictory testimony leaves the impression that the standard of care is vague, arbitrary, and unpredictable. The defendant physician is often held to a standard that reflects the "habit" of the expert testifying, which is not necessarily the "customary" standard of care. See Mark A. Hall, *The Defensive Effect of Medical Practice Policies in Malpractice Litigation*, Law & Contemp. Probs., Spring 1991, at 127; Eleanor D. Kinney & Marilyn M. Wilder, *Medical Standard Setting in the Current Malpractice Environment: Problems and Possibilities*, 22 U.C. Davis L. Rev. 421 (1989); *Expert Witnesses: Booming Business for the Specialists*, N.Y. Times, July 5, 1987, at 1.

[88] In most areas of negligence law, there exists a general "Learned Hand" test (named after Judge Learned Hand) that measures negligence under a cost-benefit analysis. *See United States v. Carroll Towing Co.*, 159 F.2d 169, 173 (2d Cir. 1947) (negligent action determined by weighing probability and severity of action against costs of precaution). Such a balancing test has never been adopted in malpractice law.

The existing climate of managed care exposes a serious structural limitation in malpractice law's reliance on custom and its insistence on a unitary standard of care. These two rules reflect an outdated image of medical decision making, one in which the physician is free to act in the best interests of the patient, unimpeded by cost. Although the courts are gradually beginning to extend liability to MCOs,[89] the law has been unwilling to adjust the standard of care required of physicians. Today's physicians are thus caught between the proverbial "rock and a hard place:" managed care may often require or encourage them to withhold care, but the tort system continues to suppose exclusive physician autonomy.

B. TRENDS IN MALPRACTICE PREMIUMS AND LITIGATION: A MALPRACTICE CRISIS?

The crisis of rising health care costs has coincided with a sense of crisis in the medical malpractice system[90] stemming from soaring insurance premiums and claims over the

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[89] *See infra* Part IV of this paper.

[90] Malpractice premiums and health care costs are related, in part, because the premium costs incurred by providers are incorporated into the fees charged to patients, although a time lag exists. Weiler, Medical Malpractice on Trial, *supra* note 7, at 4-5.

past thirty years.[91] To illustrate the problem, in 1965, the average physician in New York State paid $1,000 (in 1990 dollars) for liability coverage. By 1975, the cost for coverage had increased to $7,300, and by the late 1980s this figure was near $40,000 - a increase of 40 times in just two decades.[92]

Most of the national rise in premiums took place in two bursts: the first in the mid-1970s, and the second in the mid-1980s. Between 1974 and 1976, overall provider premiums doubled from $500 million to $1 billion; after a period of leveling off, total premiums shot up again from $2.5 billion in 1983 to $7 billion in 1988.[93] Since 1989, premiums have plateaued and even declined in some states.

Alongside the increase in premiums has occurred a concomitant increase in the number ("frequency") of

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[91] The crisis in medical malpractice since the 1960s was part of an overall crisis in tort liability generally. The area of products liability law also experienced dramatic increases in insurance premiums, claims rates, and damage awards. *See The Insurance Crisis: Now Everyone is in a Risky Business*, Bus. Wk., Mar. 10, 1986, at 88.

[92] *See* Paul C. Weiler et al., A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation 2 (1993). The cost of malpractice premiums varies greatly depending on specialty and location. Premium rates are generally determined by the claims experience of a class of physicians rather than the experience of the individual physician. Certain high-risk classes (e.g., obstetricians and surgical specialists) face premium costs of up to $200,000 per year. Weiler, Medical Malpractice on Trial, *supra* note 7, at 4.

[93] Weiler, Medical Malpractice on Trial, *supra* note 7, at 5.

successful claims filed and the amount ("severity") of damages awarded. The total liability exposure faced by an insurer is a function of the frequency and severity of claims.[94] Having failed to accurately predict the surge in malpractice litigation, several insurance carriers were forced out of business, while others precipitously raised their rates to cover large losses.[95]

The spurt in malpractice litigation since 1970 has been attributed to several causes.[96] Factors such as population growth, increased access to health care through Medicare and Medicaid, increased numbers of providers, increased use of complex medical technologies, and increased utilization of health care services contributed to the rise in claims frequency.[97] Meanwhile, the rising severity of claims may

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[94] *Id.* at 2.

[95] Medical malpractice insurance is sold by several types of insurers - commercial insurance companies, provider-owned mutual insurance funds, and joint underwriting associations with state medical societies. It is written either as an occurrence (covering any incident occurring during the policy period) or claims-made (covering only incidents for which claims are made during policy period) policy. Health Law, *supra* note 42,§ 9-1, at 335.

[96] Of all malpractice suits filed between 1935 and 1975, 80% were filed from 1970-1975. *Id.* at 332.

[97] Claims frequency increases if (1) the number of injured patients increases, (2) the number of injured patients filing claims increases, or (3) both injuries and claims-per-injury increase. According to estimates of claims frequency, roughly 1 in 25 physicians is now successfully sued for malpractice each year. Weiler, Medical Malpractice on Trial, *supra* note 7, at 3.

be attributable, in part, to general medical inflation,[98] as well as to changing legal, societal and jury attitudes.[99]

At first glance, the volatility in premiums and claims over the past thirty years understandably raises concern. But a deeper look questions whether a crisis really exists at all. Malpractice insurance premiums still represent less than 1% of total health care spending.[100] Although certain high-risk specialists still incur large premium expenses, the average physician pays $16,000 per year for insurance, representing approximately 6% of gross income. Furthermore, the evidence indicates that physicians have generally been able to pass along the increased costs of insurance by charging higher fees[101] - in real terms, their incomes have easily kept pace with premium expenses.[102]

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[98] Since malpractice awards are largely used to pay plaintiff medical bills, and since health care costs have risen so dramatically, damage awards have grown partially to keep pace with rising medical costs. Health Law, *supra* note 42,§ 9-1, at 337.

[99] Nationally, the average malpractice settlement jumped from $12,000 in 1970 to $45,000 by 1978; by 1986, it topped $100,000. In the early 1990s, a few extremely high damage awards disproportionately contributed to aggregate liability (e.g., a $127 million award against an Illinois ophthalmologist in 1991). Weiler, A Measure of Malpractice, *supra* note 92, at 5.

[100] As a percentage of total health care spending, malpractice premiums have only risen from 0.5% in 1960 to 1% today. Weiler, Medical Malpractice on Trial, *supra* note 7, at 4.

[101] But there is often a "sticky" time lag in adjusting fees to costs; given the erratic, lurching pattern of previous premium increases, this

Perhaps, then, the impression that there has been a crisis in malpractice is misplaced. However, aside from purely pecuniary costs,[103] malpractice litigation also exacts great emotional and psychological costs. A medical malpractice suit starkly places the physician-patient relationship at issue. To be sued by a patient is deeply hurtful to most physicians, because such a claim arises out of a relationship that was personal, caring, and therapeutic, not necessarily commercial.[104] Some might argue that this aspect of malpractice effects a crisis of physician morale.[105]

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may be temporarily burdensome to some physicians. *Id.* at 4-5. Premium costs are also indirectly passed along to taxpayers because insurance premiums are tax deductible expenses.

[102] It may be more difficult for physicians to pass along higher premiums in the future given the cost constraints of managed care. On the other hand, managed care may partially stem further incremental lurches in malpractice premiums by controlling health care costs.

[103] The malpractice system exerts substantial costs in the forms of insurance premiums, claims awards, and defensive medicine (estimated to be $10 to $15 billion per year). *See supra* note 9.

[104] *See* F. Patrick Hubbard, *The Physician's Point of View Concerning Medical Malpractice: A Sociological Perspective on the Symbolic Importance of "Tort Reform"*, 23 Ga. L. Rev. 295 (1989).

[105] The threat of litigation may harm the trust that exists between physicians and patients, and can breed a sense of cynicism and resentment among physicians. *See* Sara C. Charles et al., *Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation*, 142 Am. J. Psych. 437 (1985).

Nonetheless, I would focus attention on a malpractice problem that now exists, albeit of a different nature. The malpractice climate takes place within the interaction of three systems: the insurance system, the health care system, and, of course, the legal system.[106] The former two have, in many respects, fully integrated themselves in the name of managed care. Yet the legal system continues to treat malpractice law as if the three were autonomous and separate.

The "true" malpractice crisis issue is not whether physicians can absorb increases in insurance premiums, or even whether they can emotionally deal with the stress of litigation. Rather, the proper question is whether, in light of the structural changes in health care, physicians should remain a locus of negligence liability. Malpractice law continues to hold physicians to a unitary standard of care based upon custom - a custom that physicians establish.[107] But if they no longer have the ability to

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[106] *See* Weiler, Medical Malpractice on Trial, *supra* note 7, at 7-8. There are actually two insurance systems - malpractice liability insurance and health care insurance. But they are connected to each other in two important ways: (1) malpractice premiums are ultimately incorporated into health care insurance premiums via physician fees, and (2) managed care health insurance plans can affect physician utilization of services.

[107] *See supra* notes 78-89 and accompanying text.

fully implement their custom, then surely a crisis of malpractice exists.

C. MEDICAL INJURY, PATIENT COMPENSATION AND ACCIDENT PREVENTION UNDER THE CURRENT SYSTEM

The tort system no doubt exerts a burden on all its participants (doctors, insurers, even attorneys); but perhaps the greatest burden is suffered by the recipient of care - the patients.[108] They face a system that can be painstakingly slow and capricious in compensating victims, yet which also does a highly questionable job in deterring accidents. Much of the academic analysis concerning the malpractice tort system comes by way of two major studies conducted during the 1970s and 1980s.

These studies both suggest that the actual rate of patient injury due to medical negligence far exceeds the number of tort claims filed.[109] The first study, conducted

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[108] This may be particularly true with respect to the poor and elderly. Such groups may be more susceptible to injury, but less likely to have the resources to pursue claims. *See* Richard L. Abel, *Review: L's of Cure, Ounces of Prevention*, 73 Cal. L. Rev. 1003, 1006-7 (1985).

[109] Each of these studies used the same methodology of having neutral physicians carefully review the medical records of hospitalized patients: the California Study examined the records of 20,000 patients, while the Harvard Study examined the records of 31,000 patients. Weiler, Medical Malpractice on Trial, *supra* note 7, at 12.

in California in the 1970s ("California Study"), discovered that 1 in 22 of hospitalized patients suffered a disabling iatrogenic injury; of these, 1 in 6 was considered caused by negligence. Yet only 1 malpractice claim was filed for 10 such negligence events.[110]

A later study conducted in New York State by the Harvard Medical Practice Study Group ("Harvard Study"),[111] reached similar findings. Although the rate of iatrogenic injury was lower (1 in 27 hospitalizations), the rate of negligence was greater (1 in 4 iatrogenic injuries). The rate of claims filing was, however, slightly higher (1 for every 8 events of negligence) compared to the California Study.[112]

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[110] The Medical Insurance Feasibility Study, as it was called, was commissioned by the California Medical and Hospital Associations. *See* California Medical Association, Medical Insurance Feasibility Study, (Donald H. Mills ed., 1977); Danzon, *supra* note 82, at 22-25.

[111] Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990). For a comprehensive summary of the findings of the Harvard Study, see Weiler, A Measure of Malpractice, *supra* note 92; Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients*, 324 New Eng. J. Med. 370 (1991).

[112] Not all negligent injuries are "serious." Both the California and Harvard Studies' definition of "iatrogenic event" was rather broad: a prolongation of hospital stay by more than one day due to care. However, even when considering only serious negligent injuries (those to patients under 70 producing disabilities (or death) lasting more than 6 months), only 1 in 7 claims was filed in California, and only 1 out of every 3 such events in New York resulted in tort payment. *See* Danzon, *supra* note 82, at 25; Weiler, Medical Malpractice on Trial, *supra* note 7, at 12-13.

The important implication of the California and Harvard Studies, if their data can be fairly extrapolated, is that a large gap exists between the number of injuries due to negligence and those that result in malpractice claims. Approximately 1% of all hospitalized patients suffer a negligent medical injury, but claims are filed in only 10 to 15% of all instances of negligence.[113]

Yet another issue concerns the validity of the claims that do get filed. The Harvard Study went beyond the California Study by actually matching each individually filed claim of negligence with the respective hospital chart. Its findings were disturbing in that most of the claims brought were "invalid" - that is, no negligence actually occurred. This means that even fewer valid cases of negligence resulted in claims (perhaps as low as 1 in 50).[114]

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[113] A large reason for this gap is that it is difficult for patients to even know that they have been harmed by medical treatment, let alone that their provider acted below the required standard of care. Weiler, Medical Malpractice on Trial, *supra* note 7, at 74.

[114] The Harvard Study found that poor, elderly, and minority patients suffered higher negligence rates, with age and health care insurance status being the strongest determinants of negligent injury. Hospitals varied in negligence, with teaching hospitals having relatively lower rates of negligence. For a complete discussion of the data, see Weiler, A Measure of Malpractice, *supra* note 92.

Given that many negligent injuries never result in claims, and that many of the claims that do get filed are without merit, it would appear that the current tort system does a poor job in compensating the victims of negligence. Many injured victims never seek redress because attorneys hesitate to accept cases where the potential recovery does not justify the expenses of litigation.[115] Furthermore, of the victims who do receive some form of compensation (either settlement or jury verdict), the size and nature of the award tends to be distributed quite unevenly.[116] For those "lucky" enough to receive eventual compensation, the median wait is three years.[117]

Leaving aside the issue of compensation, one of the main defenses to the current tort system is its role in

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[115] Most malpractice injury attorneys are paid on a contingency fee basis, where they collect only if the plaintiff wins. Attorneys will be reluctant to accept a case that does not offer a good chance for recovery. *See* Health Law, *supra* note 42,§ 9-4, at 349.

[116] The size of jury verdicts has recently escalated, especially the portions attributed to pain and suffering as opposed to economic losses. Awards of millions of dollars are now commonplace. However, the compensation is greatly skewed as 5% of successful plaintiffs receive over 50% of the total amount of jury awards. Weiler, Medical Malpractice on Trial, *supra* note 7, at 48.

[117] According to the General Accounting Office survey of malpractice claims, the median time from injury to tort claim was 13 months, and the time from claim to payment was another 23 months. Thus, the typical injured patient waits 3 years before receiving any form of compensation. *See* U.S. General Accounting Office, Medical Malpractice: Characteristics of Claims Closed in 1984 32-35 (1987).

deterring accidents and promoting quality.[118] Some claim that the system of fault-based physician liability serves as a check against careless medical practice.[119] After all, many physicians state that they feel compelled to practice defensive medicine.[120] This argument, however, (1) overstates the degree of deterrence achievable in light of malpractice insurance, and (2) fails to appreciate the context of how most negligence actually occurs.

First, physicians do not face the economic consequences of negligence directly because any recovery will be paid by their insurer. Further, those physicians who have lost prior lawsuits generally do not pay higher premiums - their rates continue to be determined by the claims experience of a peer group of doctors practicing in the same region.[121]

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[118] Arguments have been made on both sides of this issue, but unlike the case with respect to compensation, there is little empirical data available. Thus, most arguments about the effect of tort law on prevention rely on logical inferences. Weiler, Medical Malpractice on Trial, *supra* note 7, at 72-73.

[119] For an economic analysis of tort law's deterrent effect, see William B. Schwartz & Neil K. Komesar, *Doctors, Damages, and Deterrence: An Economic View of Medical Malpractice*, 298 New Eng. J. Med. 1282 (1978).

[120] As noted before, the indirect costs of defensive medicine are substantial, ranging from $10-$15 billion per year. *See supra* note 9. But the tort system may only spur doctors to practice defensive medicine to avoid lawsuits, not to avoid patient injury - these are not necessarily the same thing.

[121] Because doctors are segmented into relatively small insurance pools, one or two huge awards can sharply drive up premiums for all members of the class, even those not responsible for any negligence. Weiler,

Although it might seem odd that premiums do not reflect one's likelihood of committing negligence, the reason they do not underlines the very nature of medical malpractice.[122]

For the vast majority of doctors, a malpractice lawsuit is a random, haphazard event.[123] This is not to say that physicians do not suffer from temporary lapses of attention, but only that inevitable human errors which produce both injury and a lawsuit are hard to predict; a past lawsuit is not a good predictor of future negligence.[124] Insurance carriers acknowledge this, and therefore price premiums to reflect the claims experience of a group of physicians.

Medical Malpractice on Trial, *supra* note 7, at 76. In addition, many physicians are unable to practice part-time or perform certain specialized procedures on a limited basis without paying a full annual premium for coverage. This may limit the availability of certain medical services in rural or inner-city areas. *Id.* at 85-86.

[122] Despite its tenuous financial incentives, tort law may still deter negligence by providing strong psychic incentives to practice good care. Physicians certainly fear the personal and professional stigma associated with malpractice suits, and they tend to overestimate the likelihood of a lawsuit by a factor of several times. Weiler, Medical Malpractice on Trial, *supra* note 7, at 76. *See also* Peter A. Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts about the Deterrent Effect of Tort Liability*, 35 Syracuse L. Rev. 939 (1984).

[123] *See* Weiler, Medical Malpractice on Trial, *supra* note 7, at 14.

[124] The deterrent effect of a malpractice suit is undermined by the infrequency of claims and unpredictability of awards. Although physicians are concerned about the threat of malpractice as a general matter, and may well engage in the "window dressing" of defensive medicine, it is unlikely that core changes in their behavior are influenced by the remote and random threat of malpractice litigation. *See* Charles et al., *supra* note 105.

Hence, a strong case has been made for expanding the burden of liability to the health care enterprise (e.g., hospital or health plan), which can better distribute the risk of negligence among a broad pool of practitioners.[125] Obstetricians presently incur premiums that may be ten times greater than those that internists pay. But this is not because obstetricians are ten times more careless than internists; rather, when errors are committed by obstetricians, the resulting harms are likely to be much greater in magnitude.[126]

A move to enterprise liability would also improve the quality of care because liability would then rest with the entity most capable of promoting quality-enhancing changes.[127] Many instances of negligence are more

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[125] Because malpractice suits tend to be a random event, it is very difficult to accurately base premiums on the claims experience of a single physician. The enterprise can price risk far more efficiently because it can draw upon the claims experience of a large group of physicians across all specialties. Weiler, Medical Malpractice on Trial, *supra* note 7, at 78.

[126] Different medical specialists have different diagnostic and treatment methods available to them. The invasiveness of surgery, for example, entails risks and harms far different than the methods commonly employed by pediatricians. The explosive growth of new medical technologies has expanded the array of caretaking approaches, but learning and mastering these technologies takes time; the "standard of care" thus evolves in a disparate manner among the different specialties.

[127] *See* Sage et al., *supra* note 14, at 13-15. *See also* Laura L. Morlock & Faye E. Malitz, *Do Hospital Risk Management Programs Make a Difference?: Relationship Between Risk Management Program Activities and Hospital Malpractice Claims Experience*, Law & Contemp. Probs., Spring

attributable to institutional characteristics than individual slipups.[128] By investing in information and management technologies, the enterprise can identify and improve upon systematic elements that contribute to negligence. An individual physician simply lacks the same resources to establish etiology and effect practice changes.[129]

The two arguments presented above for enterprise liability - efficient risk spreading and quality-enhancing systems development - are reasons enough to take the idea seriously. There is, however, a third reason why enterprise liability merits consideration: the current physician-centered tort system is not compatible with managed care cost-containment reform.

1991; Donald M. Berwick, *Continuous Improvement as an Ideal in Health Care*, 320 New Eng. J. Med. 53 (1989).

[128] For example, errors with respect to medication dosing or allergic effects are often due to deficient record tracking or charting, as opposed to incompetent professional judgment. These errors are better remedied by improving information gathering and communication at the institutional level. Sage et al., *supra* note 14, at 15.

[129] These ideas are best illustrated by a concrete case study. Concerned with the incidence and costs of anesthesia-related negligence, a group of anesthesiologists at the Harvard teaching hospitals developed a set of standards and procedures for monitoring the mishaps that commonly occur in anesthesia. Their results were impressive: the per-case cost of implementing the procedures was far less than the per-case cost of malpractice premiums, and the incidents of negligence dropped. *See* John H. Eichhorn et al., *Standards for Patient Monitoring during Anesthesia at Harvard Medical School*, 256 JAMA 1017 (1986).

A physician who feels that a certain costly procedure is "unnecessary" takes a big risk in deviating even slightly from medical custom.[130] The previous third-party payment system made it feasible for physicians to perform procedures and order tests even if their utility was questionable. However, this level of discretion is increasingly unavailable under managed care, yet liability continues to rest on the physician's shoulders. It is imperative that meaningful tort reform accompany cost-containment reform.

Before delving any deeper into the justification for managed care enterprise liability, I will next examine the attempts at tort reform to date.

D. THE STATE OF MALPRACTICE REFORM

In response to the perceived malpractice crisis, waves of statutory tort reform occurred during the mid-1970s and 1980s.[131] Much of the reform effort was led by physicians

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[130] If anything went wrong, this alone could provide the "smoking gun" of evidence for a malpractice attorney. *See* Weiler, Medical Malpractice on Trial, *supra* note 7, at 86. Of course, the problem is more complicated, because custom is not always absolutely definable. There are a variety of acceptable approaches for many illnesses, reflecting inherent uncertainty.

[131] These reforms coincided with the peak points of the malpractice premium increase crisis. Weiler, A Measure of Malpractice, *supra* note 92, at 7.

and organized medicine, who feel the economic, psychic and professional costs of the tort system. The views of many a physician are expressed in these words of a former dean of the Yale School of Medicine:[132]

> The quality of medical care today is threatened by the pervasive, unwelcome, crushing embrace of the law. Every participant in the health care system...is beset by an onslaught of new laws and regulations...Worst of all, because it is the most personal, physicians are forced to live with the spectre of malpractice litigation constantly in their mind's eye. This legal assault has occurred so swiftly and has been implemented so harshly that it has begun to erase some of the very attractions long associated with pursuing a medical career - autonomy, independence, approbation, inquiry.

Early reforms focused on the litigation process itself,[133] and attempted to reduce either the frequency of lawsuits or the severity of recovery.[134] Efforts to reduce the filing of lawsuits included shortening the statute of

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[132] Hubbard, *supra* note 104, at 344-45.

[133] Besides tort litigation reform, other reforms attempted to increase the availability of malpractice insurance. New sources of insurance were created (e.g., bedpan mutuals, joint underwriting association) and insurers were authorized to offer claims-made policies rather than occurrence policies. *See* Weiler, A Measure of Malpractice, *supra* note 92, at 7.

[134] For an overview of the various state malpractice tort reforms to date, see Agency for Health Care Policy and Research, U.S. Dep't of Health and Human Services, Compendium of Selected State Laws Governing Medical Injury Claims (1993) (reviewing the current status of tort reform laws in the fifty states); U.S. Congress, Office of Technology Assessment, Impact of Legal Reforms on Medical Malpractice Cases (1993); Frank A. Sloan et al., *Effects of Tort Reforms on the Value of Closed Medical Malpractice Claims: A Microanalysis*, 14 J. Health Pol., Pol'y & L. 663 (1989).

limitations, regulating contingency fee arrangements between plaintiffs and their lawyers, eliminating joint and several liability, and requiring alternative means of dispute resolution.[135] Meanwhile, other reforms attempted to limit the plaintiff's recovery by eliminating ad damnum clauses in pleadings,[136] allowing for periodic payments of awards, modifying collateral source rules,[137] and placing caps on damages (especially for pain and suffering) and attorney's fees.[138]

Although these statutory reforms have had varying degrees of success in stemming litigation, they attack the malpractice crisis narrowly and in piecemeal fashion. For the most part, they focus on erecting roadblocks to litigation and recovery instead of promoting quality care

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[135] These can take the form of either pretrial screening panels or arbitration. Both devices typically use a panel composed of laypersons, lawyers, and physicians. Health Law, *supra* note 42,§ 9-2, at 342-43.

[136] These are clauses in the initial pleadings which state the total amount of money requested by the plaintiff, an amount that is typically inflated beyond the level of damages actually suffered. *Id.* at 341.

[137] Collateral source rules prevent the jury from learning about other sources of compensation available to the plaintiff (e.g., personal medical insurance). This rule arguably permits double recovery of damages. *Id.*

[138] For example, California has a $250,000 limit on recovery for non-economic damages (pain and suffering) while Indiana has a total $500,000 cap per claim. Another proposal has been to schedule pain and suffering awards, rather than cap them, in order to narrow jury discretion. *Id.*

that could prevent litigation from happening in the first place. Other recent reform proposals, however, have been more comprehensive, seeking to do away entirely with the fault-based jury system.

For example, the American Medical Association ("AMA") has sponsored a system similar to Workers' Compensation that would substitute an administrative Medical Board for the jury.[139] Some legal tort scholars have suggested allowing private contract to allocate the risk of harm and compensation between providers and patients.[140] Yet another proposal is a system of no-fault liability, where all iatrogenic injuries receive compensation regardless of negligence.[141]

Perhaps the most interesting attempted reform was the State of Maine's Liability Demonstration Project ("Maine

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[139] Report of the AMA/Specialty Society Medical Liability Project, A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based Administrative System (1987). This kind of proposal, if enacted, is likely to face constitutional challenge on the grounds that it violates the right to jury trial. *See* Hugh E. Reynolds et al., A Constitutional Analysis of the AMA's Medical Liability Project Proposal, 1 Courts, Health Science and the Law 58 (1990).

[140] The major scholarly pieces addressing this topic are Randall R. Bovbjerg & Clark C. Havighurst, *Medical Malpractice: Can the Private Sector Find Relief?*, 49 Law & Contemp. Probs. 1 (1986); Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 American Bar Association Research Journal 87.

[141] See Weiler, Medical Malpractice on Trial, *supra* note 7, at 132-58.

Project").[142] In 1991, Maine passed legislation that immunized physicians from malpractice lawsuits if they practiced in accordance with certain practice guidelines. During the five-year duration of the Project, physicians who elected to participate were able to raise compliance with the guidelines as an affirmative defense to a lawsuit. The goal of the Project was to determine if malpractice premiums and the risk of lawsuits could be reduced by minimizing practice variation.[143]

Each of the proposed reforms has relative strengths and weaknesses, and they will be discussed in greater detail later. But, like the current tort system, none of the suggested reforms fully harmonizes the liability system within the existing framework of managed care. As I will argue in Part V, managed care enterprise liability offers the best means for accomplishing the normative goals of a

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[142] Me. Rev. Stat. Ann. tit. 24, § 2971 (West Supp. 1991). The Maine Project established guidelines for the areas of emergency medicine, anesthesia, radiology, and obstetrics. These guidelines were developed by advisory committees in each of the practice areas.

[143] The Maine Project had the legal effect of substituting written practice guidelines for custom as the standard of care, and was criticized on several grounds. *See* Edward Felsenthal, *Cook Care: Maine Limits Liability for Doctors Who Meet Treatment Guidelines*, Wall St. J., May 3, 1993, at A1; Robert H. Brook, *Practice Guidelines and Practicing Medicine: Are They Compatible?*, 262 JAMA 3027 (1989).

liability system (prevention, compensation, promotion of quality, and reduction of administrative expenses) because it treats cost reform and malpractice reform simultaneously and comprehensively.

IV. LEGAL RATIONALE FOR MANAGED CARE ENTERPRISE LIABILITY

A. THE HISTORICAL ORIGINS OF ENTERPRISE LIABILITY

Enterprise liability for personal injury has its origins in products liability law.[144] Traditional tort and contract law, based upon principles of individual fault and bargaining parity, reflected the norms of a pre-industrial era "dominated by small enterprises, individual merchants and independent craftsmen."[145] The beginning of the 20th century heralded the rise of the national large-scale business enterprise. The mass production and distribution of products that was achievable shifted the balance of power

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[144] Products liability law, in turn, had its origins in workers' compensation statutes. Workers' compensation had operated as a no-fault system for awarding recovery for employee accidents. Mandatory employer contributions to a recovery fund provided a strong incentive to predict and minimize accidents. For a comprehensive historical review of the development of enterprise liability law, see George L. Priest, *The Invention of Enterprise Liability: A Critical History of the Intellectual Foundations of Modern Tort Law*, 14 J. Legal Stud. 461 (1985).

[145] Friedrich Kessler, *Contracts of Adhesion-Some Thoughts About Freedom to Contract*, 43 Colum. L. Rev. 629, 640 (1941).

between consumers and manufacturers:[146] consumers often lacked the knowledge to evaluate the safety of products, and adhesion contracts gave sellers exploitative market power.[147]

The case for product enterprise liability was first made by legal academicians. Francis Bohlen proposed the benefit theory of liability, arguing that manufacturers which benefit from consumer purchases should internalize the costs of producing safe products or pay damages to victims of unsafe products.[148] Fleming James took a slightly different approach, focusing instead on which party could best absorb the risk of product injury. He explained that tort law could be fashioned not only to shift a loss from one party to another, but also to distribute risk according to insurance principles:[149]

> Human failures in a machine age cause a large and fairly regular - though probably reducible - toll of life,

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[146] See Steven P. Croley & Jon D. Hanson, *Rescuing the Revolution: The Revised Case for Enterprise Liability*, 91 Mich. L. Rev. 683 (1993) (arguing that product enterprise liability is based on imperfect consumer knowledge, manufacturer market power, and risk distribution efficiencies).

[147] Adhesion contracts refer to standardized "take-it-or-leave-it" contracts containing boilerplate clauses limiting liability. Courts often refuse to enforce the strict terms of such contracts to address egregious inequalities in bargaining power. *See* Kessler, *supra* note 145.

[148] Priest, *supra* note 144, at 466.

[149] Fleming James, Jr., *Accident Liability Reconsidered: The Impact of Liability Insurance*, 57 Yale L.J. 549, 549-50 (1948).

limb, and property....If a certain type of loss is the more or less inevitable byproduct of a desirable but dangerous form of activity it may well be just to distribute such losses among all the beneficiaries of the activity though it may be unjust to visit them severally upon those individuals who had happened to be the faultless instruments causing them.

Starting in the 1930s, the courts and legislatures began to take notice of the academic theorists, and over several decades gradually reshaped the law to protect consumers. Warranty laws and the elimination of the privity of contract requirement[150] eventually culminated in the judicial ratification of products liability law.[151] Manufacturers were now liable for injury to consumers or users even if their product was manufactured with all possible care, and even if the manufacturer did not directly sell the product to the ultimate user.

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[150] The privity of contract requirement previously hindered tort and contract law reform. Mass production requires complex distribution systems, and these intermediate links shielded manufacturers from lawsuits under traditional liability theories. *See* Keeton et al., *supra* note 80,§ 99.

[151] The New Jersey Supreme Court made one of the first judicial declarations of enterprise liability when it held both Chrysler and a car dealership liable for injuries suffered by a car buyer's spouse due to a steering defect. Hennington v. Bloomfield Motors, Inc., 161 A.2d 69 (N.J. 1960); *see also* Greenman v. Yuba Power Products, Inc., 377 P.2d 897, 901 (Cal. 1962) (Supreme Court of California reasoned that the purpose of imposing enterprise liability "is to insure that the costs of injuries resulting from defective products are borne by the manufacturers that put such products on the market rather than by injured persons who are powerless to protect themselves").

Modern consumer law firmly embraces the concept of enterprise liability. Its universal adoption in the product injury context reflects important economic realities. First, the industrial corporate entity wields enormous power over product design, manufacturing, and marketing, and elaborate distribution networks make it difficult to identify the proper tortfeasor when injury occurs. Second, the enterprise can easily spread the risk of product injuries, both by purchasing insurance and by incorporating the costs of injuries into the price of the product. Finally, placing the burden of liability on the enterprise internalizes the cost of safety, providing a powerful financial incentive to invest in safety features, quality control procedures, and truthful advertising.[152]

These principles are also applicable to medical injuries. Modern health care takes place within the confines of complex integrated enterprises. Treatment decisions are influenced by a diffuse array of decision makers, many of whom neither have contact with individual

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[152] *See, e.g.*, Gary T. Schwarz, *The Ethics and Economics of Tort Liability Insurance*, 75 Cornell L. Rev. 313 (1990); Christopher D. Stone, *The Place of Enterprise Liability in the Control of Corporate Conduct*, 90 Yale L.J. 1 (1980); Howard C. Klemme, *The Enterprise Liability Theory of Torts*, 47 U. Colo. L. Rev. 153 (1976).

patients nor owe any traditional duty of care. Even the most sophisticated patients can hardly ever achieve true bargaining parity. Meanwhile, the MCO health plan is much better suited to manage the risks of treatment and to distribute the costs of injuries. The extension of enterprise liability to managed care would logically follow not only from these principles, but also from well-established legal precedent in the health care context.

B. ENTERPRISE LIABILITY IN THE HEALTH CARE CONTEXT

Prior to 1940, most hospitals and other institutional providers were insulated from medical malpractice liability. Non-profit hospitals were protected by the "charitable immunity" doctrine - patients who accepted charitable benefits were deemed to have impleidly waived any possible negligence claims.[153] Government-owned hospitals enjoyed sovereign immunity.[154] Even for-profit hospitals were exempt

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[153] The case establishing hospital charitable immunity was McDonald v. Massachusetts General Hosp., 120 Mass 432 (1876). The court reasoned that public and private donations supporting a charitable hospital constituted a trust fund which should not be diverted by malpractice lawsuits. *See also* Schloendorff v. Society of N.Y. Hospital, 105 N.E. 92, 93 (N.Y. 1914) ("It is said that one who accepts the benefit of a charity enters into a relation which exempts one's benefactor from liability for the negligence of his servants in administering the charity").

[154] *See* Health Law, *supra* note 42,§ 7-1, at 291.

from physician negligence under the "independent contractor" doctrine, which viewed physicians not as employees, but as independent contractors who, although operating within the hospital, retained full decision making autonomy.[155]

As hospitals assumed an increasingly dominant role in the provision of health care, courts became less willing to shield them from lawsuits.[156] The 1957 case of *Bing v. Thunig*[157] was a watershed event in the decline of the charitable immunity doctrine. As noted by the *Bing* court, the ready availability of liability insurance made it less likely that damage awards would devastate the assets of a charitable institution. The rule of charitable immunity has now been completely eliminated by the majority of states, although it retains limited scope and applicability in a minority of jurisdictions.[158]

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[155] *See, e.g.*, *Schloendorff*, 105 N.E. at 93.

[156] *See* Elam v. College Park Hospital, 183 Cal. Rptr. 156, 163 (Cal. Ct. App. 1982) (court argued that the modern hospital is "a multi-faceted, health care facility responsible for the quality of medical care and treatment rendered....the patient treated in such a facility receives care from a number of individuals of varying capacities and is not merely treated by a physician acting in isolation").

[157] 143 N.E.2d 3 (N.Y. 1957). *See also* President and Directors of Georgetown College v. Hughes, 130 F.2d 810 (D.C. Cir. 1942).

[158] *See generally* Janet F. Fairchild, Annotation, *Tort Immunity of Non-Governmental Charities - Modern Status*, 25 A.L.R.4th 517, 525-46 (1983) (finding that a minority of states retain partial charitable immunity to the extent of statutory ceilings on recoverable damages or only as to

With the decline of charitable immunity, the most significant remaining obstacle to hospital liability was the notion that hospitals do not themselves provide medical care, but rather administer the equipment and facilities by which doctors, nurses, and others provide such care. Although hospitals could be directly liable for their own negligent administrative actions, they were not responsible for the medical actions of their physicians. Courts often struggled to draw the line between inherently medical as opposed to administrative activities: giving unneeded blood transfusions to the wrong patient was labeled an "administrative" error, but giving the wrong blood to the right patient was a "medical" error.[159]

Slowly, however, courts removed this distinction by finding hospitals vicariously liable, under the doctrine of respondeat superior, for the negligence of their employed physicians.[160] Vicarious liability is the principle of

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charitable care). Sovereign immunity has proved more resilient to elimination than charitable immunity. Sovereign immunity is held by the government acting in its sovereign capacity. State courts have widely split on the issue, with some eliminating it, others leaving it to the legislatures, and others retaining immunity in various forms. *See* Health Law, *supra* note 42,§ 7-1, at 291.

[159] *See Bing*, 143 N.E.2d at 4-5.

[160] *See, e.g.*, Sloan v. Metropolitan Health Council, 516 N.E.2d 1104 (Ind. Ct. App. 1987) ("It is a non sequitur to conclude that because a

agency law that imposes liability on one person for the actionable conduct of another, based solely on a relationship between the two persons.[161] Later, the vicarious liability of hospitals was extended to cover non-employed physicians, such as radiologists and anesthesiologists, under the ostensible agency doctrine.[162]

In contrast to hospitals, health care insurance plans have largely managed to retain immunity from physician malpractice liability. Under state statutes and common law rules proscribing the corporate practice of medicine,[163] lay entities like insurance companies are presumed to be incapable of exercising control over medical professionals. Instead, insurers are regulated by a separate family of

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hospital cannot practice medicine it cannot be liable for the actions of its employed agents and servants who may be so licensed").

[161] *See* Black's Law Dictionary 1566 (6th ed. 1990).

[162] See *infra* note 176-182 and accompanying text for a discussion of the ostensible agency doctrine. Excellent scholarly treatments outlining the shifting allocation of hospital liability are Diane Janulis & Alan Hornstein, *Damned If You Do, Damned If You Don't: Hospital's Liability for Physicians' Malpractice*, 64 Neb. L. Rev. 689 (1985); Arthur Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. Legal Med. 1 (1983).

[163] The corporate practice of medicine doctrine prohibits corporations from engaging in the practice of medicine. The doctrine has been severely criticized for inhibiting innovative health care organization and cost control. Its continuing status seems very much in doubt, especially in light of current trends in the medical marketplace. *See* Health Law, *supra* note 42,§ 5-10, at 183. *See also supra* notes 27 and 42 and accompanying text.

legal doctrines that impose procedural obligations concerning coverage disputes. For example, third-party payors must adjudicate claims for benefits in good faith or risk liability for unfair dealing and bad-faith breach of contract.[164]

The present lack of meaningful malpractice liability on the part of insurers stems from the historical distinction between insurance behavior and clinical care. Under managed care, however, this distinction is specious because a clear separation between the insurance function and the clinical function no longer exists. MCOs make financial and coverage decisions that directly and indirectly influence the practice of medicine. Courts are only just beginning to find bases of malpractice liability against MCOs, often analogizing from hospital liability principles.

Before discussing the bases of managed care liability, it is worth noting that an incomplete version of enterprise liability has existed since the 1970s in the form of "channeling" arrangements.[165] A number of integrated health

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[164] *See generally* John A. Appleman & Jean Appleman, Insurance Law and Practice §§ 8877-8879 (1981).

[165] *See generally* Ann P. Wood, *Channeling: Medical Liability Insurance Concept Being Widely Discussed by Hospitals*, Pediatric News, Jan. 1987, at 10; Myron F. Stevens, Jr., *A Proposal to Improve the Cost to Benefit Relationships in the Medical Professional Liability Insurance System*,

care enterprises, including the Federation of Jewish Philanthropies in New York and the Harvard Medical Institutions in Boston, offer their affiliated physicians the option of joining the institution's insurance policy.[166] If a lawsuit arises, the individual physician still remains directly liable for malpractice, but both the institution and physician are covered by one insurer, with claims jointly defended by a single defense team.

Channeling programs have not been studied thoroughly, but anecdotal evidence suggests that these programs may reduce liability costs and improve cooperation between physicians and hospitals.[167] Channeling is a step in the right direction toward full-scale enterprise liability, but it remains incomplete because liability for medical malpractice is not *exclusively* borne by the enterprise.[168]

1975 Duke L.J. 1305, 1324-31 (1975) (proposing a shift of malpractice liability exposure to institutional providers).

[166] *See* New York State Insurance Dep't., A Balanced Prescription for Change: Report on the New York State Insurance Department on Medical Malpractice 18 (1988); Harvard Affiliated Medical Institutions, Malpractice Insurance Program Information Booklet 1993-1994 at 1 (1993) (the Harvard program includes approximately 6,400 physicians).

[167] *See* Sage et al., *supra* note 14, at 17-18.

[168] Programs similar to channeling are the voluntary assumption of malpractice liability by government health systems, such as the Public Health Service, the Department of Defense, the Veterans Administration, the Indian Health Services and the Bureau of Prisons. For these entities, assuming liability simplifies the dispute resolution process

The next section highlights several of the legal theories by which malpractice liability may be extended to managed care.

C. THEORIES OF LIABILITY APPLICABLE TO MANAGED CARE

As participation in managed care has greatly increased in recent years, there has been a corresponding, though less dramatic, growth in litigation against MCOs. A few states initially granted MCOs statutory immunity from tort liability, but most now permit courts to consider common law claims against MCOs.[169] A broad spectrum of liability theories, sounding in both tort and contract law, have been asserted against MCOs.

The initial approach taken by plaintiffs and courts has been to extend by analogy the same theories of malpractice liability formerly applied against hospitals to MCOs. In

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and encourages physicians to participate in the quality-improving efforts of the entire enterprise. *Id.* at 18.

[169] For example, until 1988, Illinois provided that an HMO could not be liable for the malpractice of a member physician. Ill. Ann. Stat. ch. 32, para. 620 (Smith-Hurd 1970). *See also* N.J. Stat. Ann.§ 26:2J-25 (West 1987) (in Dunn v. Praiss, 656 A.2d 413 (N.J. 1995), the New Jersey Supreme Court held that although New Jersey's HMO Act grants immunity to certain HMO employees, it does not confer immunity on the HMO itself). But Texas still shields HMOs from direct liability for physician malpractice under the corporate practice of medicine doctrine. *See* Williams v. Good Health Plus, Inc., 743 S.W.2d 373 (Tex. Ct. App. 1987) (court referred to provision in Texas HMO Act prohibiting HMOs from practicing medicine in denying liability under a claim of respondeat superior).

test in determining the existence of an employment relationship is whether the "employer" controls or has the right to control the work performed by the "employee."[172] The label of the relationship given by the parties is not dispositive - even if the contract between an MCO and a physician states otherwise, employment status may be inferred as a matter of law if the MCO maintains sufficient control over the physician's work.[173]

Because staff model HMOs[174] directly employ physicians as salaried providers and own the working facilities, they are the form of MCO most susceptible to claims based on the respondeat superior doctrine.[175] But other forms of MCOs

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[172] Factors used in determining the existence of control include: (1) the manner of physician selection and engagement; (2) the degree of discretion and oversight over the physician's performance; (3) the custom in the industry; (4) the skill of the physician; (5) the method of payment; (6) the right of discharge; and (7) the ownership of facilities or instrumentalities used to perform the work. See generally Restatement (Second) of Agency § 220 (1984); Stewart v. Midani, 525 F.Supp. 843, 849 (N.D. Ga. 1981) (court considered eight factors in determining existence of employment relationship).

[173] *See* Keller v. Missouri Baptist Hosp., 800 S.W.2d 35 (Mo. App. 1990); Mduba v. Benedictine Hosp., 384 N.Y.S.2d 527 (N.Y. App. Div. 1976) (despite contract terms stipulating that emergency room physician was an independent contractor, hospital could be held liable under respondeat superior doctrine if it exercised sufficient control over the physician).

[174] *See supra* notes 48-55 and accompanying text.

[175] *See Sloan*, 516 N.E.2d at 1109; Schleier v. Kaiser Foundation Health Plan, 876 F.2d 174, 177-78 (D.C. Cir. 1989) (a staff model HMO was held vicariously liable under respondeat superior for the negligence of an independent consulting cardiologist; although Kaiser did not select nor

(e.g., PPOs and IPA model HMOs) may also be subject to respondeat superior claims, depending on the degree of control exerted over providers. Certain indicia of control, such as capitation, utilization review, practice parameters, and provider selection and discharge, may satisfy the presence of a quasi-employment relationship.

In cases where respondeat superior may be inapplicable, another theory by which to find MCOs vicariously liable for physician negligence is ostensible agency.[176] The ostensible agency theory examines the patient's expectations regarding treatment, and asks whether the health care organization created the appearance of an agency relationship between itself and the negligent physician. Two factors are central to this analysis: (1) whether the patient looks to the institution rather than the individual physician for health

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compensate the cardiologist for his consultation, the court found that Kaiser had the ability to control the cardiologist's work since he answered directly to Kaiser's primary care physician who had consulted him).

[176] *See* Restatement (Second) of Torts § 429 (1965) ("one who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants").

care, and (2) whether the institution "holds out" the physician as its agent.[177]

Establishing these factors is often an expensive, fact-intensive inquiry. The MCO's advertising and marketing efforts can be crucial pieces of evidence in determining whether the MCO created a reasonable presumption in the eyes of the patient that the physician was an agent of the MCO. In one case, for example, a Michigan HMO patient had to have an arm amputated after misdiagnosis by a consulting radiologist. The HMO was liable for malpractice because it promised plan members "complete health care services."[178] On the other hand, an Illinois HMO was able to avoid ostensible agency liability, in part, by specifically informing patients that it does not provide medical services.[179]

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[177] *See, e.g.*, Jackson v. Power, 743 P.2d 1376 (Alaska 1986) (because hospital failed to emphasize that its emergency room physicians were not employees, it had a non-delegable duty to provide non-negligent emergency room care); Hardy v. Brantley, 471 So.2d 358 (Miss. 1985) (ostensible agency applied where hospital advertised itself as a provider of quality medical care).

[178] Decker v. Saini, No. 88-361768 NH, 1991 WL 277590, 4 (Mich. Cir. Ct. Sept. 17, 1991) (as a matter of public policy, the court noted that "imposing vicarious liability on HMOs for the malpractice of their member physicians would strongly encourage them to select physicians with the best credentials").

[179] Raglin v. HMO Illinois, 595 N.E.2d 153 (Ill. Ct. App. 1992).

Because the status of a physician as an independent contractor or employee is irrelevant in determining liability, ostensible agency may apply to all forms of MCOs.[180] In *Boyd v. Albert Einstein Medical Center*,[181] an IPA model HMO was liable under ostensible agency theory when a physician performing a breast biopsy punctured the chest wall of the plaintiff's wife, resulting in her death. The *Boyd* court noted several factors justifying the appearance of an agency relationship: (1) the HMO's advertising and marketing presented the HMO as "a total care program;" (2) the patient's contractual relationship was with the HMO and not the physician; (3) the patient had a limited choice of physicians; (4) the physicians were subject to the HMO's cost and quality control programs.[182]

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[180] A closely related theory of vicarious liability is "agency by estoppel," which requires that actual detrimental reliance be shown. *See* Restatement (Second) of Agency § 267 (1984) ("one who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such").

[181] 547 A.2d 1229 (Pa. Super. Ct. 1988). *But cf. Raglin*, 595 N.E.2d at 154 (a limited list of providers was not dispositive as to ostensible agency theory because "this is the manner in which all HMOs operate").

[182] *Boyd*, 547 A.2d at 1235.

b. Direct Negligence Liability

In addition to vicarious liability for physician malpractice, MCOs may face direct liability for injuries to patients. MCOs can be directly negligent either in the selection and control of their physicians, or in the design and implementation of their cost-containment mechanisms.

The doctrine of corporate negligence first emerged in *Darling v. Charleston Community Memorial Hospital*,[183] in which the plaintiff's leg had to be amputated after negligent orthopedic surgery was performed by an unqualified emergency room physician. The *Darling* court found the hospital directly liable for failure to credential physicians properly in the performance of orthopedic surgery, and thereby established a hospital's duty of care to use only qualified and competent physicians.[184]

Darling led to a series of decisions expanding the duties a hospital owes directly to patients. Hospitals now owe independent duties to exercise reasonable care in the selection, retention, supervision and monitoring of their

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183 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966).

184 *Id.* at 258.

medical staffs.[185] The corporate negligence theory has been further extended to MCOs, especially in the area of provider selection and retention. Because most MCOs restrict a patient's choice to a limited pool of providers, plaintiffs have alleged that an MCO has a duty to review and investigate the credentials of its physicians properly. An MCO may be liable for physician malpractice if it failed to credential and select the physician appropriately.[186]

The other component of the corporate negligence doctrine is the duty to supervise the quality of medical care rendered by staff physicians. A hospital may be liable for negligent supervision or monitoring if it fails to detect physician negligence or take steps to correct potential problems. Although there have been no published

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[185] *See Elam*, 183 Cal. Rptr. at 164 (hospital owes duty to adequately monitor medical staff physicians); Pedroza v. Bryant, 677 P.2d 166 (Wash. 1984) (hospital has duty to monitor and control physicians who are treating patients within hospital); Johnson v. Misericordia Community Hosp., 301 N.W.2d 156 (Wis. 1981) (hospital owes duty to investigate qualifications of medical staff adequately); Bost v. Riley, 262 S.E.2d 391 (N.C. 1980) (hospital has duty to monitor and oversee patient treatment).

[186] *See* William A. Chittenden III, *Malpractice Liability and Managed Health Care: History and Prognosis*, 26 Tort & Ins. L.J. 451, 470-71 (1991); McClellan v. Health Maintenance Organization, 604 A.2d 1053, 1059-60 (Pa. Super. Ct. 1992); Harrell v. Total Health Care, 1989 WL 153066 (Mo. Ct. App. 1989), *aff'd on other grounds*, 781 S.W.2d 58 (Mo. 1989) (en banc). Beyond a common law duty to investigate the credentials of physicians, federal and state regulations require some level of provider credentialing as a condition of qualification and licensure. *See, e.g.*, 42 C.F.R.§ 417.107(i) (1989).

opinions imputing similar liability to MCOs, they are already subject to federal and state quality assurance regulations.[187] As courts increasingly characterize MCOs as health care providers, and the collection of quality assurance data become more available, suits against MCOs for negligent physician supervision and control are likely to surface.

A separate category of direct liability for MCOs concerns their cost-containment mechanisms, such as utilization review. In accordance with utilization review procedures, MCOs may refuse to authorize certain treatments that are medically "unnecessary." If in hindsight, such denial of treatment results in injury to the patient, the MCO may be liable on grounds of negligent interference with the health-care decision making process.[188] The case of *Wickline v. State of California*[189] was the first to address the potential liability of a third-party payor, such as an

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[187] *See, e.g.*, 42 U.S.C.§ 300(e)(c)(6) (1988); Cal. Health & Safety Code, §§ 1351(m), 1367(b), 1370, 1380 (Deering 1992); Mich. Comp. Laws Ann.§ 550.53(5) (West Supp. 1992).

[188] Bearden & Maedgen, *supra* note 34, at 325.

[189] 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).

MCO, for injuries resulting from utilization review decisions.

The plaintiff in *Wickline* was covered under Medi-Cal, California's medical assistance program for indigents. Diagnosed with Leriche's syndrome,[190] the plaintiff entered the hospital for vascular surgery; Medi-Cal, employing a prospective utilization review process, authorized a ten-day hospital stay. After post-surgical complications arose, the plaintiff's surgeon requested an eight-day hospital extension, but was given authorization for only four additional days. Without appealing the decision, the surgeon discharged the plaintiff after the four-day extension expired. Several days later, the plaintiff's situation deteriorated to the point where her leg had to be amputated. In her complaint, the plaintiff alleged that Medi-Cal's negligent administration of utilization review caused her premature discharge, resulting in her amputation.[191]

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[190] Leriche's syndrome is a condition due to vasoocclusive disease of the aortoiliac segment. The classic symptoms include impotence, buttock atrophy, and claudication. Peter F. Lawrence, Essentials of General Surgery 333 (1992).

[191] *Wickline*, 239 Cal. Rptr. at 811-17.

The actual holding of the *Wickline* court found Medi-Cal not liable, primarily because the plaintiff's surgeon complied with the four-day extension without filing a second request for additional days. However, *Wickline* has significance not so much for its holding, as for its dicta:[192]

> The patient who requires treatment and who is harmed when care which should have been provided is not provided should recover for the injuries suffered from all those responsible for the deprivation of such care, including, when appropriate, health care payors. Third party payors of health services can be legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden.

Thus, *Wickline* leaves the door open to claims against MCOs for injuries resulting from negligent utilization review. Future plaintiffs may extend *Wickline's* invitation beyond utilization review, by asserting claims based on the financial incentive and risk-sharing devices of MCOs.[193] In

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[192] *Id.* at 819.

[193] Very few published cases currently exist concerning MCO liability for injuries caused by negligent cost-containment strategies. *But see* Wilson v. Blue Cross of Southern California, 271 Cal. Rptr. 876 (Cal. Ct. App. 1990); Bush v. Dake, No. 86-25767 NM-2, slip op. (Mich. Cir. Ct., Saginaw County Apr. 27, 1989) (one of the few cases where an HMO's financial incentives were alleged to have caused physician malpractice).

the meantime, however, the physician is caught in a Hobson's choice dilemma as explained by the California Medical Association's amicus curiae brief in *Wickline*:[194]

> The patient who is injured when care which should have been provided is not provided will recover from someone. If the third-party payor imposing these controls is permitted to avoid liability by maintaining the fiction that the mechanisms have only fiscal consequences, so that patient care is solely the physician's responsibility, the physician becomes the insurer. If rationing malfunctions, the physician who complies with the program is liable to the patient. If the physician does not comply, the physician is punished or faces responsibility for incurring authorized costs.

2. Theories of Contract Liability

Tort theories based on negligence are the most often used causes of action in malpractice suits. Yet, other potential bases of recovery exist, most notably theories of contract liability. Because the relationship between an MCO and its subscribers arises out of contract, contract theories may be asserted in addition to, or as an alternative to tort-based theories, particularly when case-specific proof problems or legal defenses may preclude negligence-based claims. These contract-based theories of

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[194] Chittenden, *supra* note 186, at 480.

malpractice include breach of contract, breach of warranty, bad faith in the handling of claims, and fraud.[195]

A breach of contract claim was brought against both a primary-care physician and IPA model HMO in *Williams v. HealthAmerica.*[196] In her contract action, the plaintiff alleged that she suffered injuries from a delay in referring her to a specialist. The basis of her claim was that the HMO breached its contract by failing to deliver health benefits as promised (i.e., the right to be referred to a specialist in a timely fashion).

In general, health care providers are not held to guarantee cures or good results. But many MCOs, in their marketing and advertising materials, purport to assure high quality care. Representations of quality may be interpreted by courts and juries as promising that certain standards of care will be met, and may provide the basis for a breach of

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[195] The liability claims of bad faith and fraud are not contract claims *per se*, but rather tort claims that arise out of contractual obligations. Under either theory, plaintiffs can recover both compensatory (actual) and punitive damages in excess of policy obligations. *See* Health Law, *supra* note 42,§ 11-3, at 507-08.

[196] 535 N.E.2d 717 (Ohio Ct. App. 1987) (the court upheld the breach of contract action against the physician, but recharacterized the action against the HMO as a tort claim for bad faith in the handling of claims). *See also* Yunker v. Kaiser Foundation Health Plan, 611 P.2d 314 (Or. Ct. App. 1980).

warranty claim. Such assurances, however, must be distinguished from "mere puffery," which would not rise to the level of a warranty.[197]

An MCO may be liable for bad faith in the processing of claims. To establish bad faith, a plaintiff must prove that the MCO acted egregiously in wrongfully denying coverage or delaying payment of a claim.[198] In the dramatic case of *Fox v. Health Net of California*,[199] the HMO refused to pay for a costly bone-marrow transplant to treat advanced breast cancer, alleging that the procedure was too "experimental." Deciding that the HMO acted in bad faith in breaching its contract, the jury awarded the plaintiff's estate a stunning $12 million in compensatory damages, and $77 million in punitive damages.[200]

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[197] *See, e.g.*, Pulvers v. Kaiser Foundation Health Plan, 160 Cal. Rptr. 392, 393 (1979) (a breach of warranty claim was rejected on grounds that alleged warranty of good result was no more than "generalized puffing to the extent that the [HMO] doctors would exercise good judgment in their care"). *But see Boyd*, 547 A.2d at 1235-36 (court found factual issue as to "whether the literature in which HMO 'guaranteed' and 'assured' the quality of care to its subscribers, had been distributed to .... [the plaintiff]").

[198] *See* Health Law, *supra* note 42,§ 11-3, at 508.

[199] 3 BNA Health Law Rptr. 18 (Cal. Super. Ct. Dec 23, 1993).

[200] In finding bad faith, the *Fox* jury heard testimony that the HMO's decision was made to save money for the organization, over the opposition of the HMO's own physicians. *See* Ellen Pollock, *HMO Held Liable for Refusing Coverage*, Wall St. J., Dec. 28, 1993, at B5.

Claims based upon common law fraud or state consumer fraud statutes are yet another conceivable avenue for recovery. Assertions in MCO contracts and marketing brochures, or omissions of material information from these documents, that induce the patient to subscribe may be actionable in fraud. For example, in *Teti v. U.S. Healthcare*,[201] the plaintiffs brought suit in federal court alleging fraud and violations of the Pennsylvania Unfair Trade Practices and Consumer Protection Law.[202] They complained that the HMO's failure to disclose its physician compensation arrangements, which included financial incentives to minimize the use of medical services, induced their enrollment in the HMO.[203]

3. Potential Hurdle of ERISA Preemption

An important potential barrier to MCO malpractice liability is preemption by the Employment Retirement Income Security Act of 1974 ("ERISA").[204] ERISA is a comprehensive

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[201] 1989 WL 143274 (E.D. Pa. 1989), *aff'd* 904 F.2d 696 (3d. Cir. 1990).

[202] Pa. Stat. Ann. tit. 73§ 201 (Purdon 1971 & Supp. 1990).

[203] The case was ultimately dismissed for lack of federal court jurisdiction, and no other case to date has recognized a duty to disclose cost-containment incentives.

[204] 29 U.S.C.§§ 1001-1461 (1994).

federal statute designed to regulate employee benefit plans. It sets minimum uniform standards and provides for uniform remedies in the enforcement of the plans. Health insurance benefits have long been a form of employee compensation, and in many instances, an MCO is sponsored by an employer through a self-funded benefit plan.

Congress explicitly provided that ERISA preempts state laws to the extent that they "relate to" employee benefit plans not otherwise exempt from federal regulation.[205] The preemptive provision was intended to establish pension plan law as an exclusively federal concern. The issue with respect to MCO malpractice liability is whether such state claims "relate to" the benefit plan, and are thereby preempted by ERISA.[206] The Supreme Court has concluded that a state law "relates to" a benefit plan if it has a connection with or reference to such a plan;[207] yet, the

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[205] 29 U.S.C.§ 1144 (1994).

[206] The possibility of ERISA preemption is significant because plaintiffs would then be limited to the much more restricted remedies provided by ERISA. In general, extracontractual and punitive damages are not recoverable under ERISA. *See* Massachusetts Mutual Life Insurance Co. v. Russell, 473 U.S. 134, 146 (1985). Also, plaintiffs are not entitled to jury trial under ERISA and must pursue their claims in federal court. *See* Brown v. Retirement Committee of Briggs & Stratton, 797 F.2d 521, 528-30 (7th Cir. 1986).

[207] Pilot Life Insurance Co. v. Dedeaux, 481 U.S. 41, 47 (1987) (state common law claims for bad faith, intentional infliction of emotional

Court has also noted that "some state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan."[208]

A broad discussion of ERISA preemption is beyond the scope of this paper, but the evolving trend in the federal courts is that state law vicarious liability claims against MCOs are *not* preempted by ERISA.[209] However, courts have been more willing to apply ERISA preemption to direct liability claims (i.e., claims based on corporate negligence or the negligent administration of utilization review). The general reasoning behind ERISA preemption in these instances is that direct liability claims "relate to" an MCO benefit

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distress, breach of fiduciary duty, breach of contract and fraud relating to denial of plan benefits were preempted).

[208] Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1983).

[209] *See, e.g.*, Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3d Cir. 1995) (ERISA did not preempt vicarious liability claims based on ostensible agency theory because they were claims about the low quality of benefits received, rather than claims to recover benefits due or to enforce or clarify plan benefits); Rice v. Panchal, 65 F.3d 637 (7th Cir. 1995) (vicarious liability claim of respondeat superior not preempted by ERISA); Elsesser v. Hospital of Phil. College of Osteopathic Medicine, 795 F.Supp. 142 (E.D. Pa. 1992) (claims of negligence, misrepresentation and breach of contract were not preempted), *vacated* 802 F.Supp. 1286 (E.D. Pa. 1992).

plan because they concern the manner by which the MCO administers or provides the plan's benefits.[210]

4. Summary of Managed Care Liability

Despite the failure of the Clinton Plan to mandate enterprise liability, the further judicial development of MCO liability seems inevitable. Changing public attitudes toward the contemporary health care marketplace will make it easier for courts throughout the country to further extend analogous hospital liability principles to MCOs. Whether brought under theories of tort or contract, the variety of potential malpractice claims against MCOs is matched only by the structural variety of the organizations themselves.

Unfortunately, the sheer variety of liability theories only underscores the lack of a systematic approach to managed care liability. Nowhere is there a system of "true" enterprise liability, where malpractice liability would be

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[210] *See, e.g.*, Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298 (8th Cir. 1993) (malpractice claim against HMO for refusal to precertify payment for heart surgery related to the administration of benefits, and was therefore preempted); Corcoran v. United Healthcare, 965 F.2d 1321 (5th Cir. 1992) (malpractice claim against HMO's utilization review for wrongful decision that hospitalization was not necessary involved a benefit determination, resulting in preemption), *cert. denied*, 506 U.S. 1033 (1992); Altieri v. Cigna Dental Health, Inc., 753 F.Supp. 61 (D. Conn. 1990) (ERISA preempts direct claim for negligent supervision and retention of physicians because it relates to the administration of benefits plan).

borne exclusively by the health care enterprise on behalf of its affiliated physicians. So long as physicians remain independently liable for malpractice, the inherent tensions between the tort system and cost reform will continue to exist.

As a matter of public policy, the uniform adoption of "true" enterprise liability is desirable in several important respects. First, it would lend predictability to the dispute process by eliminating the confusion in the courts as to what doctrine to apply in malpractice cases. Even though theories of MCO liability are expanding, they are creatures of state law whose applicability now differs widely from state to state. Second, compared to the present tort system, enterprise liability would better accomplish the normative goals of a liability system in light of managed care cost containment.

V. ECONOMIC AND PUBLIC POLICY RATIONALE FOR MANAGED CARE ENTERPRISE LIABILITY

A. THE NORMATIVE GOALS OF A LIABILITY SYSTEM

The crucial public policy issue is whether enterprise liability would be an improvement over traditional

malpractice law, or any other tort reform. The answer depends on the criteria used to evaluate a liability system. An often-stated justification for tort liability is the value of corrective justice. This value is a statement of moral culpability, requiring that "wrongs" committed by negligent physicians be corrected through payments to innocent patients. In fact, the current malpractice system serves this value only in a remote fashion.

Malpractice lawsuits against physicians are not paid for by the individual physician, but by the physician's insurer.[211] The insurer collects malpractice premiums from physicians who finance these overhead costs through the treatment fees charged to patients. Patients, in turn, pay for physician fees by acquiring insurance either directly or through their employers or the government. Thus, the tort system functions within an elaborate, circular system of insurance that essentially requires all potential patients to insure against the risk of negligently-caused injury. On this view, the primary challenge of a liability system is not to achieve corrective justice per se, but to offer the

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[211] Furthermore, the premiums paid by physicians typically do not reflect their individual claims experience, but are based on the claims experience of a group similar specialists in the same locality. *See supra* notes 121-124 and accompanying text.

fairest and most efficient form of insurance to patients injured by malpractice.[212]

Guido Calabresi, former Dean of Yale Law School, argues that the economic aim of accident law is to reduce the sum of the costs of accidents and the costs of avoiding accidents.[213] To this end, he identifies three normative goals of an ideal liability system: (1) compensation of injured victims, (2) prevention of accidents, and (3) minimization of administrative expenses.[214] In the context of medical malpractice liability, I would add a fourth goal: the promotion of quality health care. With this general framework in mind, enterprise liability will first be compared to the present tort system, and then to alternative models of liability.

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[212] *See* Weiler, Medical Malpractice on Trial, *supra* note 7, at 44-47.

[213] Guido Calabresi, The Costs of Accidents: A Legal and Economic Analysis (1970).

[214] *Id.* *See also* Steven Shavell, Economic Analysis of Accident Law (1987); William M. Landes & Richard A. Posner, The Economic Structure of Tort Law (1987).

B. ENTERPRISE LIABILITY COMPARED TO THE PRESENT TORT SYSTEM

As discussed in Section III, the current system does a poor job compensating the victims of malpractice.[215] Enterprise liability would replace the individual physician with a much larger "deep pocketed" defendant, and perhaps encourage a greater number of lawsuits. But because enterprise liability would still require that fault be shown - that is, a plaintiff would still have to prove that a physician or the MCO itself was negligent - it is uncertain whether more victims would receive compensation, or whether awards would be more predictably and fairly distributed. Many of the same hurdles to patient compensation (e.g., attorney reluctance to accept small-recovery cases, imperfect information as to the cause of patient injury, inherent uncertainties in the dispute process) would still exist under enterprise liability.

Compared to the present system, enterprise liability would almost certainly reduce many of the administrative costs associated with medical malpractice.[216] Enterprise

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[215] *See supra* notes 108-117 and accompanying text.

[216] It has been estimated that only about 40 percent of the total amount expended in the malpractice claims process actually reaches injured patients as compensation for their injuries. On the other hand, the

liability would reduce litigation costs by substituting a single defendant for multiple, individual defendants. Any case with multiple defendants is more complicated, time consuming, and expensive because of the problems in reconciling the differing interests of the parties.[217] Enterprise liability would also achieve efficiencies in the pricing of malpractice insurance. A large MCO can obtain insurance to reflect the claims experience of a group of affiliated physicians across all medical specialties, and thereby spread the costs of insurance over this larger risk pool.[218] Moreover, enterprise liability would reduce the costs of defensive medicine, estimated to be $10-15 billion per year.[219]

The greatest advantage of enterprise liability over the current system is with respect to the goals of injury

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Workers' Compensation program is estimated to expend only 20 percent of its claims dollar on administrative expenses, roughly one-third the proportion spent in medical malpractice. *See* Weiler et al., A Measure of Malpractice, *supra* note 92, at 29.

[217] Nearly 25 percent of malpractice claims now have two or more defendants. *See* Weiler, Medical Malpractice on Trial, *supra* note 7, at 127.

[218] *See supra* notes 125-126 and accompanying text.

[219] *See supra* note 9. Additional social costs of the existing system include the refusal of physicians to practice in certain high-risk specialties and the lost services of physicians who must devote uncompensated days to defend against a malpractice claim. *See* Weiler, Medical Malpractice on Trial, *supra* note 7, at 80-90.

prevention and quality promotion. Enterprise liability has the ability to reconcile the seemingly contradictory objectives of cost control and quality because it forces the MCO to internalize the consequences of its cost-containment efforts.[220] As patients increasingly look to institutions rather than individual practitioners for care, enterprise liability is consistent with the idea that these institutions are "ultimately responsible for arranging, providing, and coordinating the activities of a host of professional persons, all of whom must work together in the care of patients."[221]

Supporters of the current system have argued that enterprise liability would weaken the tort system's preventive role because physicians would no longer have to fear the possibility of a malpractice lawsuit. Physicians do tend to overestimate the risk of being sued, and the sheer unpleasantness of litigation no doubt deters to some

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[220] MCOs should be efficient quality managers because they are better able than individual physicians to assess the quality of care they deliver in the aggregate, and have the financial resources to invest in information technologies. Continuous quality management requires training physicians, comparing the effectiveness of medical procedures, and developing practice guidelines that embody empirical data. *See supra* notes 127-129 and accompanying text for a discussion of these and other injury prevention and quality management techniques.

[221] Southwick, *supra* note 162, at 47-49.

extent.[222] I would argue, however, that the main safeguards against physician carelessness are strong professional ethics and concern over reputation, not the threat of a malpractice lawsuit.

These strong personal incentives will continue to exist under enterprise liability. Injured patients could still exact enormous costs on the physician - income, stress, damage to reputation - by litigation undertaken to establish the fault of the physician in order to recover from the MCO. Physicians who demonstrated a systematic pattern of negligence could be disciplined and even terminated by the MCO. Rather than weakening the preventive incentives of the current system, enterprise liability preserves them because it still requires that physician negligence be shown.

Many physicians fear that a move toward enterprise liability will erode their autonomy, and reduce their status from independent professionals to mere employees. Some prefer to retain individual liability for negligence rather than cede any further control over the standards of

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[222] However, the presence of malpractice insurance and the random nature of malpractice lawsuits attenuate the deterrence ability of tort law. Most malpractice suits arise in connection with momentary lapses of attention that are hardly influenced by the threat that an adverse verdict might materialize years later. *See supra* notes 118-126 and accompanying text.

treatment to MCOs.[223] As a future physician, I am sympathetic to these objections, but I believe they contemplate a health care world that has long since passed.

The reality is that a host of actors besides MCOs already challenge the discretion of physicians. The courts, lay juries, hospital administrators, and government regulators all regularly exercise significant influence.[224] In the integrated health networks of the present and future, physicians must function as members of teams, but their role on the team will always be a central one. The very nature of clinical variability assures that physicians will retain a large degree of professional judgment; the difference now is that their control over medical resources is not exclusive, but shared.

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[223] Richard Corlin, M.D., expressed the AMA's House of Delegates position toward enterprise liability: "One proposal Clinton's made that is absolutely nonnegotiable is enterprise liability, which means that if you work for an HMO and get sued, you could get fired. This will lead to a firestorm like nothing they've ever seen. If they want a doctor strike, this is the best way to do it." *On the Road Again: Media Tour Pushes AMA Reform Message*, Am. Med. News, May 17, 1993, at 1, 7.

[224] For instance, the National Practitioner Data Bank ("NPDB"), a registry of malpractice judgments and disciplinary actions, was established by the Health Care Quality Improvement Act of 1986, and effective 1990. The goal of the NPDB was to stimulate the peer review process on the part of health care institutions. *See generally* Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications, and Implications*, 16 Am. J.L. & Med. 453 (1990).

C. ENTERPRISE LIABILITY COMPARED TO ALTERNATIVE SYSTEMS

Besides enterprise liability, a number of other models of comprehensive tort reform have been suggested: (1) the AMA's administrative fault proposal, (2) contract law as a replacement for tort law, and (3) a no-fault liability system similar to Workers' Compensation. Using the same framework of analysis, these proposals will now be compared to enterprise liability.

The essence of the AMA's proposal is to move malpractice cases away from juries and into a forum that would permit a more informed professional appraisal.[225] This proposal may achieve better and more timely compensation, especially for small claims, and may also reduce the administrative costs of litigation. However, it may not achieve efficiencies with respect to malpractice insurance pricing, and more importantly, would seem to do little to enhance injury prevention. Switching the forum from a jury to a Medical Board does not treat the issues of cost reform and malpractice reform simultaneously, and leaves physicians in the untenable position that they may be liable for decisions that are beyond their control.

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[225] *See* Health Law, *supra* note 42,§ 9-5(d), at 356-58.

Private contracts instead of tort litigation could be used as a compensation system. Under this approach, providers would voluntarily contract with patients to cover certain outcomes, allocating between themselves the risks and responsibilities of treatment. Contracts allow for a great deal of flexibility, as the parties could agree in advance to issues such as the standard of care or liability, damage limitations, and alternative dispute mechanisms such as arbitration.[226] Such proposals have been popular with libertarian academics, but effective contract law requires a degree of bargaining parity between the parties that infrequently exists in the medical context.[227]

Under a no-fault liability system, all victims of iatrogenic injury would be eligible for compensation regardless of negligence. Proponents of this system argue primarily for its superior compensation features.[228]

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[226] Courts have been very hostile in allowing the parties to waive tort liability via private contract, viewing this as against public policy. *See* Tunkl v. Regents of the University of California, 383 P.2d 441 (Cal. 1963) (the position of the California Supreme Court in *Tunkl* has been unanimously adopted by every state court which has addressed the issue).

[227] The same problems of contract law in products liability (e.g., information asymmetries, adhesion contracts) exist in the medical context. *See supra* notes 144-152 and accompanying text. For a more extensive discussion of contract law as a proposed reform model, see Weiler, Medical Malpractice on Trial, *supra* note 7, at 93-113.

[228] *See* Kenneth S. Abraham & Paul C. Weiler, *Enterprise Medical Liability and the Evolution of the American Health Care System*, 108 Harv. L. Rev.

However, a no-fault system would almost certainly escalate claims and insurance costs. Even under the present system, the majority of claims that are filed are spurious.[229] Thus, it is reasonable to assume that the number of claims filed under no-fault would rise dramatically since plaintiffs would only be required to show that an iatrogenic injury was suffered without also having to prove that it was negligently caused.[230]

Although no-fault would relieve plaintiffs of the costs of proving negligence, there would still exist the administrative costs of proving *causation*. Patients presumably seek health care because they are already ill, and it would be extremely difficult and costly in many cases to determine whether an injury was the result of medical intervention or a natural progression of disease.

With respect to injury prevention, no-fault may be as effective as enterprise liability in generating

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381 (1994); Jeffrey O'Connell, *Expanding No-Fault Beyond Auto Insurance: Some Proposals*, 59 Va. L. Rev. 749 (1973).

[229] *See supra* note 114 and accompany text.

[230] The total costs under a no-fault system could be much greater than under the present tort system. *See* Maxwell J. Mehlman, *Saying "No" to No-Fault: What the Harvard Malpractice Study Means for Medical Malpractice Reform*, *in* N.Y. State Bar Ass'n, Special Comm. on Medical Malpractice (Jan. 1991).

institutional safety incentives.[231] However, it may actually weaken such incentives on the part of the individual physician. If patient compensation no longer turns on the issue of physician fault, the deterrent effect of a fault-based system may be compromised. Nevertheless, among the competing models of tort reform, no-fault deserves the most consideration as a serious alternative to enterprise liability.

VI. IMPLEMENTATION OF MANAGED CARE ENTERPRISE LIABILITY: CONCERNS AND SUGGESTIONS

Over the past 20 years, medical malpractice has generated more state experimentation and interdisciplinary research than any other component of the civil justice system. Enterprise liability as a model of malpractice reform has yet to be implemented anywhere, despite having substantial legal and economic policy bases. Yet, without the lessons that would be gained from an actual experimental trial, the relative benefits and drawbacks of enterprise

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[231] Because the institution would be responsible for all iatrogenic injury, it would have strong financial incentives to seek out sources of iatrogenic injury and minimize them through information gathering and management techniques. *See* Weiler, Medical Malpractice on Trial, *supra* note 7, at 144-50.

liability cannot be empirically assessed. The following are some of the transitional issues that would have to be addressed in order to determine the effectiveness of enterprise liability:

- <u>Methods of Implementation</u>. Pursuant to the authority of an enabling statute, enterprise liability could be offered on an elective basis, or mandated, to a group of MCOs in a specified geographic region.[232] Under either approach, all affiliated physicians, whether or not they were employees, would be immune from malpractice lawsuits. Physician liability would be retained, however, for any intentional torts committed.

- <u>Complementary Insurance Adjustments</u>. Because physicians would no longer need to purchase independent malpractice insurance, there would need to be adjustments made to the system of insurance arrangements. First, affiliated physicians would pay an annual surcharge to reimburse the MCO for its increased insurance costs.

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[232] An alternative to placing enterprise liability on MCO health plans would be to make hospitals the locus of enterprise liability. For a discussion of these two competing proposals, see Sage et al., *supra* note 14, at 9-15; Abraham & Weiler, *supra* note 228, at 415-20.

However, this surcharge would be expected to be much less than the prior cost of individual insurance. Second, physician reimbursement schedules would have to be decreased because the overhead cost of individual malpractice insurance is incorporated into the physician's fees.

- Complementary Tort Reform. Because enterprise liability replaces the physician with an impersonal, "deep-pocketed" defendant, this may encourage a sharp increase in the frequency and severity of claims. To enhance the compensation function of enterprise liability, it may be necessary to include some of the traditional tort reforms that many states have attempted.[233] These would include damage limitations for nonpecuniary losses (e.g., pain and suffering), collateral source offset rules, and alternative means of dispute resolution.[234]

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[233] In states still following the common law rules with respect to tort damages, forty to fifty percent of the compensation paid is for pain and suffering, the bulk of which is concentrated on the five percent of successful claimants with the most serious injuries (who represent perhaps two or three of every 1,000 victims of malpractice). Moreover, of the remaining compensation paid for strict economic losses, perhaps as much as sixty percent is already covered by public and private insurance programs (collateral sources). *See* Weiler, Medical Malpractice on Trial, *supra* note 7, at 48-54.

[234] *See supra* notes 133-138 and accompanying text.

- Out-of-Network Physicians. Many patients continue to receive medical care either from physicians not affiliated with any MCO, or under traditional fee-for-service arrangements (e.g., indemnity plans or Medicare). In these situations, managed care health plans would not be able to respond appropriately to the financial incentives created by enterprise liability, and physicians would have to maintain individual malpractice coverage for non-network patients. The benefits of a uniform legal rule would be diminished under these circumstances.[235]

VII. CONCLUSION

The current issues in health care reform require a comprehensive rethinking of the connections between the medical financing and delivery systems, and the civil justice system. In a time when physicians operated as autonomous independent contractors, a liability system of

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[235] Enterprise liability has its greatest potential in situations where physicians are directly affiliated with one or a handful of competing health plans that are paid capitated premiums. Physicians with a multiplicity of affiliations would be less likely to develop allegiances to particular MCOs, and would be subject to confusing and potentially contradictory quality control procedures. The adoption of enterprise liability would force MCOs to adopt more careful selection criteria, and may encourage physicians to consolidate their affiliations. *See* Sage et al., *supra* note 14, at 24-25.

individual responsibility was appropriate. That time has since passed. Medicine is now delivered and financed through a system of integrated enterprises, and control over health resources is shared among an array of actors. Yet the liability system has to failed to evolve beyond its original design.

The challenge before us now is to redesign a single liability system that will secure the optimal blend of these often-competing objectives: sensible and fair compensation, effective prevention of injury, promotion of quality care, and economical administration. The law is not a panacea for solving the numerous complex issues involved in health care, but it can play a significant role in aligning cost reform with our other normative goals. To maximize the contribution that tort law can make to this effort, malpractice liability should rest with the enterprise that can best manage the care that patients receive.